JANUARY 23 1999

CHEMIST & DRUGGIST

THE NEWSWEEKLY FOR PHARMACY

PSNC takes two year view on remuneration

MCA calls for legal age of 16 for GSL nicotine gum

Quit smoking advice kicks off health pilot

Mawdsleys 'saves' an independent

Pharmacy Plus buys up nine pharmacies

Update: *executive stress can raise the blood pressure*

We're making it easier to recommend the treatment women want.

We're backing Diflucan™ One with a £2.25 million advertising campaign this year, starting with a national TV burst now. And a year round press campaign, which will inform your customers of the price up front. Ensuring Diflucan One remains the fastest growing vaginal thrush treatment. Diflucan One already accounts for over 1 in 4 sold,[1] proving that a treatment that's oral, fast and effective is the one thrush sufferers want.

It's getting easier to recommend all the time.

Pfizer Consumer Healthcare

(1) IRI Infoscan MAT 1 14 98

Abbreviated product information for Diflucan One. Presentation: Capsule containing 150mg fluconazole. **Indication and dosage**: Vaginal candidiasis. Adults (16-60 years) single oral 150mg dose. **Contra-indications**: Hypersensitivity to fluconazole or related azoles, pregnancy and women of childbearing potential unless adequate contraception is employed, co-administration of terfenadine and cisapride. **Warnings**: Lactation. Not recommended. **Drug interactions**: Relevance to single-dose has not yet been established. Anticoagulants, astemizole, cisapride, cyclosporin, diuretics, oral sulphonylureas, phenytoin, rifampicin, terfenadine, theophylline and zidovudine. **Side-effects**: Nausea, abdominal discomfort, diarrhoea, flatulence and rarely anaphylaxis. **Legal category**: [P]. **Package Quantity and Cost Price**: 150mg capsule, pack of 1, £7.12 (PL1906/0017). **Product Licence Holder**: Pfizer Consumer Healthcare, Wilsom Road, Alton GU34 2TJ. **Date of preparation**: December 1998

CHEMIST & DRUGGIST

THE NEWSWEEKLY FOR PHARMACY

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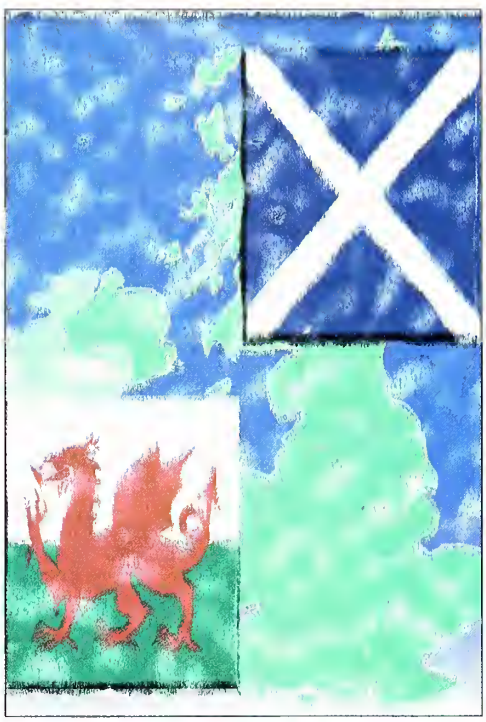
REGULARS

COMMENT

Perhaps contractors will understand now what PSNC chairman Wally Dove means when he says pharmacists should not grumble that their pay increase has been slow in coming. They've already had it through increased productivity (see p4). There is no backdated lump sum this year so that contractors can 'catch up' after the usual delays. PSNC has sensibly decided to take a two year view and keep fees and allowances unchanged until later this year (although any change will be backdated to April). PSNC is still smarting from accusations that last year's division of the global sum favoured smaller contractors. By applying any increase to the professional allowance, it can be seen to be even handed. In practical terms, though, pharmacies with larger NHS turnovers will see a lower percentage increase. After the unwelcome news on the size of the discount clawback, contractors must be hoping PSNC does not have any more bad news to put on the table before the LPC conference on April 8.

"The Government's year-on-year focus on costs is understandable, but it offers the profession little scope to improve the services it offers to the public. Government wants pharmacy to play a bigger role in delivering healthcare services. Pharmacy is eager to pick up the challenge, but to do that we need proper levels of investment. Today's funding arrangements are exhausted and outmoded. The Government needs to put in place a thorough review which creates a funding system that allows pharmacy to deliver the primary healthcare services which we need for the new millennium."

Fine sentiments - the official position from the mighty Boots, no less - but where are the practical, viable alternatives to the present system? Not in last week's remuneration document from the Royal Pharmaceutical Society, which was sadly lacking. It's time for some original thought.



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No backdated change in fees for 98-99 as PSNC takes two-year view

Pharmacists expecting a backdated increase in prescription fees and allowances following the belated 1998-99 pay settlement are going to be disappointed.

Having looked at a number of options for changing fees and allowances in February and March, the Pharmaceutical Services Negotiating Committee decided last week to leave them unchanged. The basic fee per item stays at 91.4p and the practice allowance for those dispensing over 1,600 items a month at £1,830.

To distribute the 1998-99 global sum fairly would have involved significant changes in February and March, and reversals in April, explained chairman Wally Dove. "We have decided to take a two-year view rather than have a yoyo effect for two months."

PSNC has concluded that no changes should be made to fees or allowances in this financial year (except for the essential small pharmacy scheme). Changes will be considered over two years by comparing projected average core monthly income in 1999-2000 with that of 1997-98.

This situation has arisen because the 3 per cent rise to the global sum this year has effectively already been paid out in fees for the increased number of prescriptions contractors have had to dispense, which means there is no spare cash to boost fees (see box).

Looking ahead to April 1999-2000, PSNC has decided that the global sum should be "distributed as equally as possible across all contractor groups" (less any overpayments carried forward and excluding the £12.25m for point of dispensing checks).

This means the proportion paid as prescription fees will be reduced and the professional allowance increased. The POD money, since it is volume-related, will be paid out at 2.3p per prescription as an addition to the fee.

In general terms, smaller contractors dispensing over 1,100 prescriptions a month (the lower threshold for the professional allowance) will benefit the most. The ultimate losers will be among the 384 pharmacies in England and Wales who dispense less than 1,100 items a month and are not classed as essential small pharmacies.

Until the 1999-2000 global sum is agreed, together with the forecast prescription volume, and the true level of overpayment for this year calculated, PSNC cannot say what the dispensing fee and professional allowance will be for the next financial year.

If the pay settlement follows its normal pattern, the amounts will not be known until around October, although they should be backdated to April. "The professional allowance is likely to be increased, with the dispensing fee staying at a fairly similar level to 1998-99," predicts the PSNC.

- **The Essential Small Pharmacy Scheme:** the annual target payment is to be increased by 3.26 per cent to £36,640 for 1998-99. This will be implemented as soon as possible.

Explaining the figures

The globol sum for 1998-99 wos recently finalised at £732.4 million (1997-98 £709.3m), an increase of 3 per cent. A sum of £1.85m wos ogreed for troining stoff ond contractors for point of dispensing (POD) checks due to stort on April 1.

The NHSE hos forecost an increose in prescription volume of 3.5 per cent for 1998-99. Assuming existing fees ond ollowonces continue until the end of Morch this will mean a £2.4m overspend on the 1998-99 globol sum. This is in oddition to o £2.9m overspend brought forword from 1997-98.

Under the orrangement with the DoH, if the total fees paid to contractors exceeds the ogreed globol sum by £250,000 then the DoH con 'recover' the overspend the following year.

To reduce the forecost overpoyment of £5.3m for 1997-99, PSNC hos decided that the £1.85m for POD troining should not be paid out as cash, but should be offset ogoinst thot figure, reducing the cumulotive overpoyment ot Morch 31 to £3.4m.

However, one glimmer of sunshine is that unofficiol estimotes ot the end of third quorter put the increose in prescription volume at 2.5 per cent. This could meon the level of overspend ot the end of 1998-99 is less thon expected.

IN BRIEF

Resignation: PSNC's south-west regional representative Toni Allen has resigned following the sole of his business. An election will be held to fill the voconcy. Choirmon Wolly Dove poid tribute to his "exceptional dedication" in representing an oreo from Lond's End to Gloucester.

Welsh Assembly: PSNC is to lobby condidotes for the Welsh Assembly in the run up to the elections in May. Briefing pocks will be provided for Welsh LPCs.

Patient Packs: PSNC said no progress is being mode over potient pocks because the Government "has decided to obondon the initiotive os o means of implementing the EEC Directive on Labelling ond Leofleting".

LPC Conference and PSNC Dinner: Despite being told he wos "boring", health secretory Frank Dobson is back as chief guest ot the PSNC dinner on April 8. Over 170 porliomentorions hove so for said they will attend. The conference earlier in the doy will see o remunerotion update, o debote on resolutions ond o presentotion on medicines monogement.

PSNC has 'been there already' on models of remuneration

The Pharmaceutical Services Negotiating Committee says it has, at one time or another, looked at all the models put forward in last week's paper on remuneration from the Royal Pharmaceutical Society.

In a low key but dismissive response, chairman Wally Dove said that most of the alternatives have not been progressed on the grounds that they are not in the interests of community pharmacy, or that they are simply impractical.

"I am disappointed that the Society spent so much time rubbishing the current system," he added. "What we have got is not perfect, but a lot of people have tried to find a better system and have not come up with one."

PSNC said it is eager to see community pharmacy develop, but it does not think contractors would support a system based on devaluing and undermining the core dispensing function to release money to pay for additional services.

"The size of the cake is the main problem. If the current system was properly funded there would not be the same level of discontent," said Mr Dove.

PSNC said it will continue to explore alternative remuneration models, but is sticking to the line that additional funding must be provided for additional services.

CHIC issues cold leaflet

Pharmacies will be receiving copies of a new Consumer Health Information Centre leaflet on colds and flu over the next few weeks for distribution (a sample will come with next week's issue).

About 100,000 copies of 'How to win the cold war' are being distributed by wholesalers to pharmacies. A similar quantity will be distributed by community nurses, through GP surgeries and school sickrooms.

Further copies can be obtained by calling the CHIC pharmacist helpline on 0845 60 61 611, fax 0171 421 9317.

Pharmacy numbers remain rock steady

The number of pharmacies in England and Wales has remained fairly constant over the past year.

At the end of September 1998 there were 10,496 pharmacies in contract with health authorities, almost the same as six and 12 months earlier. Over the preceding six months, 23 pharmacies opened up and 20 closed.

Three-quarters of those closing were within 500m of another pharmacy; 96 per cent of those opening were at least 500m from the nearest pharmacy while 65 per cent were at least 1km away. The number of pharmacies in contract changed by no more than three in any HA, according to the Department of Health's latest Statistical Bulletin, 'Community pharmacies in England and Wales: September 30, 1998'.

Just over half (54 per cent) of pharmacies received payment for providing additional agreed hours of service.

MCA proposes to further restrict GSL nicotine gum

The Medicines Control Agency is proposing to make it illegal to sell or supply nicotine gum to people younger than 16. However, it is still consulting on its first proposal to allow nicotine gum, up to 2mg strength, to be available as a General Sales List medicine to aid smoking cessation for people aged 16 and over.

In a January 12 supplement to consultation letter MLX 248, the MCA proposes to amend the Sale or Supply Regulation to make it a criminal offence to sell or supply nicotine gum to a person under the age of 16 years.

"The Committee on Safety of Medicines advised that nicotine gum may safely be on general sale but with a legal restriction to prevent sale to children aged less than 16 years," says the MLX supplement.

The National Pharmaceutical Association is reserving judgement on the proposal, but director John D'Arcy said on Tuesday that he would be interested to see if the CSM has made the recommendation based on clinical data suggesting a safety aspect relating to the age.

"It's not clear why a legal mechanism is being sought," he said. "It may be there is clear clinical evidence, but it is more likely this is a political move to bring NRT in line with cigarette sales. Why is it any different from aspirin or paracetamol?"

He also sees problems with checking proof of age and commented that although the government wants greater access for NRT, this could be restricted if it requires a prescription. "If it does go into legislation, I would hope and expect there would be a due diligence defence," he added.

He suggested that by extending the MCA's line of thought, it could be argued that if someone goes into a pharmacy asking for a hangover cure, then they should have to be over 18 years old.

Comments on the MCA proposal should be sent to the MCA by February 8, 1999. The MCA is planning to implement this change with the others outlined in MLX 248 so that the Statutory Instrument comes into force by March.

Quit smoking scheme kicks off health pilot

A smoking cessation pilot scheme, using a multidisciplinary approach, is about to go live in Northumberland.

The pilot is the result of extensive research carried out by the Pharmacy Healthcare Scheme and the National Pharmaceutical Association in developing a long-term strategy for health promotion in pharmacy.

Funded equally by the health authority and PHS, the pilot will involve five pharmacies and three GP surgeries to find the best ways for primary care professionals to work together to support smokers who want to stop. The HA is supplying seven days' free nicotine replacement therapy to smokers committed to quitting.

A protocol, based on Health Education Authority guidelines, has been devised so that consistent messages are given to those wanting to stop smoking, said PHS project manager Rubina Mohammed.

Alison Strath, the NPA's community pharmacy development co-ordinator for Scotland and Northern Ireland, said the aim is to develop a model of multidisciplinary working that could apply to other health promotion activities.

"In this pilot we hope to end up with a 'how to do it guide' so that other health authorities can implement local, multidisciplinary smoking cessation schemes," she told *C&D*.

The participants are about to start training, which will include assessing smokers' attitudes, advice on how to stop, regular support and follow-up, and helping those who relapse. GPs will be encouraged to refer patients to pharmacies for NRT. Payment for pharmacists is still being negotiated by the LPC.

An evaluation of the project be available by the end of March. "At this stage we are looking at practical issues and methods of working rather than evaluating outcomes," said Ms Strath.

The pilot sites are in Alnwick and Bedlington Station.

Product recall

Quinoderm Ltd is recalling two batches of its Hydromol Cream 500g due to incorrect labelling of the expiry date. The batches affected are LF8274 and LF8275. Date of manufacture and batch number are correctly printed on both batches. The company says there is no MCA classification for this recall and that products should be returned to the supplier for credit. Quinoderm can be contacted on 0161 624 9307.

Young dentists confident

Nine out of ten young dentists are confident about the future of private dentistry, compared to 16 per cent confident about NHS dentistry. Seven out of ten would like the option of becoming a salaried employee, a British Dental Association survey says.

Boots employees appear before magistrates

Two Boots employees, charged with manslaughter, appeared before Halton Magistrates Court, Cheshire, on Tuesday.

No plea was made by Lisa Taylor Lloyd, a pharmacist, or Ziad Khattab in their first appearance before magistrates. The two were working at Boots in the Hallwood Health Centre, Runcorn New Town, when the incident was alleged to have occurred in the spring of last year.

The two only confirmed their names and dates of birth. Their separate defence solicitors commented that the alleged incident had occurred in April 1998, yet seven months later on January 4, the Crown Prosecution Service had only released the committal papers.

In view of the difficult, complex matters surrounding the cases, the defence did not wish to return to court without further progress. Consideration had to be given to the file and it was agreed that the next appearance would be on March 30.

The chairman of the bench consented to renewal of unconditional bail for both Ms Taylor Lord and Mr Khattab, but stressed the grave nature of the charge to the defendants.

IN BRIEF

Scottish statistics for August 98

There were 4,501,432 prescriptions dispensed in Scotland in August, 1998, 4,492,503 by chemist contractors, at a total cost to the exchequer of £46,186,789. For chemist contractors, the ingredient cost per prescription was £9.143, dispensing fees were £0.9804 with a professional allowance of £0.363 and on-cost of £0.002. The gross total per prescription was £10.7015 or £10.1341 net. The average CD fees cost per prescription was £0.0641.

... and N Ireland in September

There were 1,868,386 items dispensed from 1,094,580 prescription forms in Northern Ireland in September, 1998. The ingredient cost was £19.13 million (£17.9m net). Discount was £1.228m, with on-cost and other payments totalling £2.966m. The gross cost was £20.87m (£20.3m net). Gross cost per prescription was £11.1694 with ingredient cost £10.2392. The net ingredient cost per prescription was £9.5821.

AAH Hospital Service guide

AAH Hospital Service has produced a guide for NHS Trust managers on procuring medicines. 'Managing medicines effectively' includes information on drug purchasing and contracting, expenditure and technological initiatives.

Primary care research

'Research opportunities in primary care', a book looking at research options for GPs and their teams in a variety of settings, has been published by Radcliffe Medical Press, at £18.50. Its ISBN is 1-85775-242-2

GPs set for 3.5 to 4 pc pay rise?

The GP pay review body is believed to have recommended that GPs be given a pay rise of between 3.5 and 4 per cent, and that it should not be staged, according to a report in this week's *Pulse* magazine. The British Medical Association had called for a 10 per cent rise for all doctors.

WHO guide to testing for drugs

A book providing a step-by-step guide to simple methods for testing the identity of common medicines and medicinal forms has been published by WHO. 'Basic tests for drugs', ISBN 92-4-154513-5, is available from the Stationery Office, priced £16.25.

Flather honoured

Gary Flather QC was honoured on Tuesday with a dinner held for him by the Royal Pharmaceutical Society's Statutory Committee, which he chairs, to celebrate his award of an OBE in the New Year Honours list.

NHS Trusts advised on FP10HP changes

Revised hospital prescription forms, FP10HP and FP10HP (Ad), should soon be appearing, after going into production this month.

Forms are being changed to help point of dispensing checks of patient entitlement to free prescriptions. In addition, the box saying 'Doctor's name and initials in block capitals' will be reinstated. Other changes to the forms include an age and date of birth box.

NHS Trusts are being told that units which print prescriptions should ensure that both age and date of birth are printed for all patients after April 1. Prescribers using FP10HP and FP10HP (Ad) who hand write the prescription should include the patient's date of birth details from April – as this is the primary information needed for verification of exemption claims.

HEA report gives guidelines on smoking cessation

An NHS strategy to help people stop smoking could cut smokers numbers in England by 75,000 per year, according to a Health Education Authority report.

Recommendations include the provision of brief advice from pharmacists and other health professionals, more widespread use of nicotine replacement therapy, and setting up specialist smoking cessation clinics.

The report forms the first evidence-based guidelines on smoking cessation in England. Based on studies in the UK and US, it is endorsed by 21 medical and professional bodies, including the Royal Pharmaceutical Society and the National Pharmaceutical Association.

The guidelines will be issued across the NHS. They recommend that health professionals follow a 'four A' plan:

- ask about smoking at every opportunity
- advise all smokers to stop
- assist the smoker to stop by offering simple tips and planning the role of nicotine replacement therapy
- arrange follow up, including referral to a specialist smoking cessation service where appropriate.

Advice to smokers for as little as three minutes from a GP results in a 2 per cent cessation rate, the report says. If 50 per cent of smoking patients were given this advice, it would result in 18 people quitting in a five partner practice, or 75,000 throughout England, estimates the HEA.

The second part of the report explains the cost-effectiveness of smoking cessation. The median cost of over 310 medical interventions is estimated to be £17,000 per life year gained. Smoking cessation interventions prove considerably more cost-effective at between £212 and £873. The HEA estimates that it would cost health authorities about £330,000 per year to establish a comprehensive smoking cessation strategy.

MCA aims to increase aspirin 75mg pack size

The Medicines Control Agency wants to increase the maximum pack size of aspirin 75mg tablets or capsules that can be sold as a Pharmacy medicine to 100, and it is seeking to allow topical preparations of hydrocortisone with nystatin to be sold as P medicines.

In its consultation letter MLX 251, issued on Monday, the MCA acknowledges the concern that the restriction of analgesic pack sizes last September may adversely affect the supply of low dose aspirin used long-term to prevent heart disease and stroke.

"Larger pack sizes of up to 100 tablets or capsules of 75mg strength aspirin, sold or supplied under the supervision of a pharmacist, would be more convenient for these patients and would not be inconsistent with the aim of the original restrictions," it says. This also follows advice from the Committee on Safety of Medicines that it would be safe to do so.

Referring to the switch from Prescription Only to P status for topical hydrocortisone with nystatin, the CSM has advised that hydrocortisone 0.5 per cent in combination with nystatin 3 per cent may safely be supplied for the treatment of intertrigo in which yeast (*candida albicans*) is a factor, only if the maximum pack size is 15g.

The MLX also seeks to add some recently licensed POMs to Schedule 1 to the POM Order. These are candesartan cilexetil, lornoxicam, losartan potassium, nebivolol hydrochloride, nisoldipine, propiverine hydrochloride, quetiapine fumarate and tacalcitol monohydrate.

The consultation period is shorter than usual "so that we can take forward action on the aspirin 75mg proposal as quickly as possible", it says. Comments to reach Dugan Cummings, room 1109a, MCA, Market Towers, 1 Nine Elms Lane, London, by February 10.

SB rolls out PharmAssist programme for 1999

Smithkline Beecham's 1999 PharmAssist training programme has been launched with a new smoking cessation module.

Although training is non-product based, the module "complements" SB's new product Niquitin CQ. Users of the module work their way through a series of questions guided by icons indicating where discussion is required.

Overall, the three-tier programme covers six key therapy areas – NRT, analgesics, colds and flu, gastrointestinal, dermatological and oral care – professional retailing, and strategic planning which includes the Certificate in Community Pharmacy Management offered through *C&D* in conjunction with Belfast's Queen's University.

SB says the smoking cessation module focuses on the key role played by the pharmacist and pharmacy assistant in advising and supporting customers who would like to quit. "Smoking advice is a key category where professional advice and guidance can make a vital impact," says SB's Vicky Hampson.

For more details contact Ms Hampson or Lydia Mackay on 0181 975 3085 or 0181 975 4400.

Leaflets, posters and guidelines to help with POD checks

By the middle of February pharmacies will receive leaflets and posters, plus a set of staff training guidelines from the NHS Executive, to help them deal with point of dispensing (POD) checks.

Guidance will be provided on acceptable forms of evidence to be accepted and a dedicated telephone advice line will be provided from the middle of next month.

The NHS will ensure that the public is informed that from the beginning of April they will be expected to provide proof of prescription exemption. An extensive advertising campaign, using press and poster sites, will start in March. Patients will also be offered a telephone advice line.

These details are being sent out to contractors in a letter jointly signed by Jim Gee, director of counter fraud services at the NHSE, and Pharmaceutical Services Negotiating Committee chairman Wally Dove.

Pharmacists will not have to ask for proof of age – that should be printed on the prescription. Where pharmacists are in possession of the evidence of exemption, they will have to mark the form to this effect.

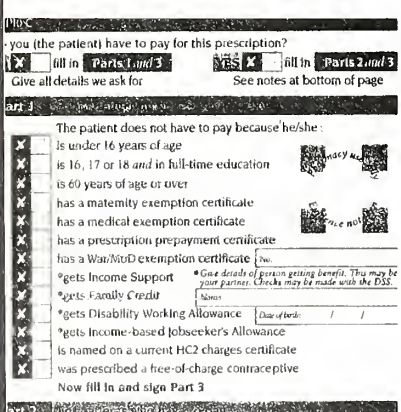
No changes will need to be made to the way prescriptions are sorted before they are sent to the Pricing Authority.

New prescription forms are also being introduced into GP surgeries for April 1. They carry a four square box (see illustration) for pharmacists to tick if they are not shown evidence of exemption.

PSNC stresses that if, after April 1, pharmacists are presented with the old style FP10, a tick should be placed in the same place as the box appears on the new form if no exemption evidence is produced.

The new form is designed to be machine scanned to pick up unverified exemption claims, hence the need for the tick to be in the right place.

PSNC is seeking a further amendment to the form, with support from the Pricing Authority. It is proposing that the box in which medication items are written should be white, to make it easier to decipher computer generated script made unreadable by an old printer ribbon.



Pictured at the first session of the year are five of the 38 participants from Croydon, south London

GP PERSPECTIVE

GPs uncomfortable in the public spotlight

As the new year dawns and GPs get back to normal work after the Christmas break, it is a good time to look ahead and see what is likely to happen. In general practice the development of primary care groups remains the key interest.

Though PCGs will have a great impact on GPs' working patterns, it is other factors that will affect individuals more. Doctors, just like other health professionals, are aware of an increasingly stressful working environment.

The pressure comes from more demanding patients and a greater workload. Throw in the fear of complaints and litigation and the climate is not always that comfortable.

The public perception of the profession is changing. Several high profile cases involving errant doctors appeared in the press last year. And

"Public perceptions of the medical profession are changing"

there are more to come. These cases put the spotlight on the bad side of medical practice and will increase the calls for tighter regulation.

The professional watchdog, the General Medical Council, is trying to raise standards. Recently the GMC suspended a GP registrar (a GP in training) for a year, simply because of his poor medical ability. This was the first time that such an order has been made on these grounds.

Overall GPs have recently felt under siege and morale has been poor. Retention and recruitment of new GPs has proved difficult. General practice is not as popular as it has been. And it is likely that as the millennium approaches, it will continue to have problems.

However, all is not doom and gloom. The pay review body may give GPs a more realistic pay rise. And there is also an extra £60 million in the pot from last year's pay review.

Though extra remuneration is welcome, it does not solve issues such as poor morale and high levels of stress. The answers to these problems are not that simple but many of the political issues affecting GPs will highlight them. Perhaps 1999 will be the year that general practice turns the corner.

By Dr Harry Brown, a GP practising in Seacroft, Leeds.

Xrayser

Topical Reflections

RPSGB has failed to get to grips with the pay issue

The Royal Pharmaceutical Society has published a discussion document on finding better remuneration models for community pharmacists. It has been put together, as I understand it, because the Society said it would look at such issues as part of the 'New Age' programme.

Such a document should deserve an in-depth examination. It is the working party that put it together which should provide the ideas for breaking the gridlock of inertia that has become the hallmark of negotiations with the Department of Health over the past few years.

However, out of hope has emerged despair. This document merely rehearses the same ideas that have been debated in these columns for years. None of them get to the nub of the problem. Compromise arguments and suggestions have been dissected *ad nauseam* for as long as I have been in practice. The Society's discussion document is a classic compromise of irrelevance.

The present contract is fundamentally flawed. It makes supply side averaging the basis for remuneration and ignores professional service and the wide disparity in the costs of individual contractors.

Before any discussion, the NHS Executive must publicly accept the proposition that remuneration should be based on professional service, and that costs should be accurately and individually reimbursed.

An agreement to attain these twin goals might then allow an academic discussion document to become the basis for an impassioned debate on how they should be achieved.

Microtab gets a lukewarm response

A few months ago I would have received the news that Pharmacia & Upjohn has developed a new sublingual nicotine replacement therapy, Microtab, with enthusiasm.

Nicotine gum achieves its purpose of providing nicotine replacement on demand, but is disliked by many customers. Chewing gum is socially unacceptable and I have developed almost as much a hatred for gum as I have for tobacco. As far as my carpet tiles go, I would prefer tobacco!

A direct alternative to nicotine gum should be very welcome and as a Pharmacy product I should be enthusiastically recommending the advantages of Microtab. However, my enthusiasm has, predictably, been tempered because I know that I am probably being used as a controlled test market for the eventual 'GSL' reclassification of Microtab.

The harder I work to make a success of the product, the greater is the likelihood that P&U will eventually stab me in the back, apply for a GSL licence and proudly display Microtab alongside its gum cousin on every supermarket shelf in the country.

Stock shortages hitting a sore spot

I have just been told by my main wholesaler that it is unable to supply warfarin tablets and that it has none in any of its depots. I have also been told that this shortage is general but no-one knows how long it will continue.

Needless to say, this is pretty unsatisfactory. Shortages always seem to occur after Christmas: a combination of seasonal demand, the disruption caused by the extended holiday period and the closure of a lot of British industry for two weeks.

However, this year seems worse than previous ones and is going on for longer. Pavacol-D, Naseptin, Alupent Syrup, Pancrex and now warfarin are among my latest problems, and even the medicines counter is not immune. The new packs of Syndol have not been available for months, Milk of Magnesia is like liquid gold and I have to buy dispersible aspirin 300mg from my kindly local cash and carry!

Oh well! January is almost over and supplies will eventually recover. My staff think I am like a bear with a sore head, but it can be very frustrating to be unable to provide either products or information. Dotty puts it all down to SID - senility imminent disease!

More miracle cures ... at a price

The end of the feasting season always produces a rash of miracle slimming products and this year has been no exception.

First we had Bonsal, the priceless, unobtainable, but heavily advertised miracle from Aerolab, and now - even more inviting - is Calorad, which claims to increase lean muscle and burn off fat while you sleep! I'd love to see the *bona fide* research that backs this one up! At £55 for one month's supply the only thing it seems guaranteed to lighten is the wallet!

Stocking a top selling pregnancy test kit is now as easy as one, two, three...

For some women getting pregnant isn't as easy as one, two, three... from the thousands of calls made to our customer care helpline we found that the majority of women who want to have children plan up to six months in advance. However a significant number take even longer to conceive.

These are the women who are the ***multi-test*** users, they test month after month hoping for a positive result. When asked if they would prefer to purchase a ***3 test*** pack if it were available, 50% said yes. Their main reason was that when faced with potentially expensive regular monthly outlays the three test pack offered an economic alternative.

Since Early Bird® has always provided a value for money brand for pregnancy testing, it made sense to add the new ***3 test*** pack to our range to enable women to choose the pack size that most suited their individual needs.

1 test - for "one time users" **2 tests - for those who want to "double check"** **3 tests - for the "multi-user"**

£5.75 **£9.75** **£7.75**

Early Bird® - as easy as 1,2,3 for pharmacists and consumers!

Available from all major Wholesalers.

Kent Pharmaceuticals Limited, Wotton Road, Ashford Kent TN23 6LL. England.

Counterpoints

Pharmaton relaunched to tackle daily fatigue

A new OTC category - daily fatigue - has been created with the relaunch of Pharmaton.

Boehringer Ingelheim Self Medication aims to highlight the benefits of Pharmaton's ginseng-based multivitamin and multimineral formulation as a remedy for daily fatigue. The company defines daily fatigue as a "complex, multicausal, multidimensional, non-specific and subjective phenomenon for which no one definition is widely accepted", and claims that as many as 61 per cent of the population suffer from the condition and 80 per cent of them fail to treat it.

A training pack entitled 'Get up and grow' has been produced for pharmacists and their assistants. And a £3.8 million national TV campaign will run from February until December, with 86 per cent of viewers expected to see the commercial nine times on average.

Pharmaton contains 40mg standardised ginseng extract G115. The brand continues to carry a Pharmacy licence.

Boehringer Ingelheim Ltd. Tel: 01344 424600.

SB takes caring approach with Panadol

SmithKline Beecham Consumer Healthcare will be supporting Panadol with a new £280,000 press campaign which starts at the end of January.

The striking campaign will feature a creative execution of the Panadol elephant family pictured in a blue tint with the strapline 'You can even take it on an empty stomach'.

Appearing in women's interest magazines, the campaign will target mothers and carers with the sign-off 'For those you care for'.

SmithKline Beecham Consumer Healthcare. Tel: 0181 560 5151.

AAH to build new own-label range

AAH Pharmaceuticals is launching a comprehensive new range of own-label products.

The Supersave range will comprise 120 new products with the emphasis on value for money. It will include oral hygiene, haircare and VMS products as well as deodorants, moisturisers, tissues and camera films.

The lines are designed to complement the pharmacy products available under the Vantage banner.

The first items will be available to AAH customers from mid-February, with further products being launched over the following few months.

AAH Pharmaceuticals Ltd. Tel: 01203 432400.

A mix up of flavours for Halls Soothers

Adams Confectionery is launching a new mixed flavour pack in its Halls Soothers medicated confectionery range.

Halls Soothers Assorted packs include three different fruit flavoured throat lozenges in one ten piece stick pack. The packs feature the existing blackcurrant and orange flavours plus a new strawberry flavour.

According to the company's research, consumers want to see new flavours in medicated confectionery. Strawberry is the most popular fruit flavour in regular confectionery.

Retail price is £0.49.

Adams Confectionery. Tel: 01703 620500.

Kwai goes heart-shaped on TV

Lichtwer Pharma is supporting its Kwai garlic supplement with a £1 million TV advertising campaign.

Running on Channel 4 and selected regional stations, the campaign features new Kwai ACE, Kwai Original and Kwai Once-a-Day.

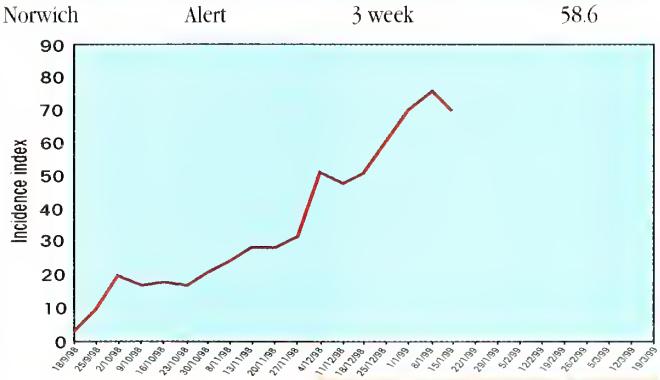
In the commercial, a garlic bulb changes into a heart before becoming the Kwai garlic tablet, to highlight the product's claim to help maintain a healthy heart.

Chemist Brokers. Tel: 01705 222500.

Cough, cold & flu FORECAST

Information updated weekly by SDI

City	Status	Weeks on status	Incidence index for this week
Birmingham	**Alert**	**3 week**	47.5
Bristol	Alert	4 weeks	68.0
Glasgow	**Alert**	**3 week**	66.7
Leeds	Alert	7 weeks	61.8
London	**Alert**	**4 weeks**	75.2
Manchester	Alert	5 weeks	80.9
Newcastle	**Alert**	**4 weeks**	69.2
Norwich	Alert	3 week	58.6



SPONSORED BY Benylin

MARKET STATUS
ALERT
(week 5)

Leakproof pack for Foamburst Gel

Cussons has introduced new packaging for its Imperial Leather Foamburst Gel.

The shower products now feature a tamper-evident disc on the top of each can. The new disc is designed to minimise accidental product activation in-store and prevent spillage by consumers.

The range comprises four variants - Radiance, Delight, Vitality and Fitness. Retail price is £2.99 (200ml).

Cussons (UK) Ltd.
Tel: 0161 491 8000.

Lighten up with blonding shampoo

Jerome Russell is launching a new blonding shampoo and complementary conditioner.

B Blonding Shampoo contains peroxide and is designed to gradually lighten hair. B Blonding Enriched Conditioner is formulated to protect the hair after shampooing. Both products retail at £2.95.

Jerome Russell Cosmetics Ltd.
Tel: 01708 554000.

New distributor for Yardley brands

Dendron is the new distributor for Tweed, Panache, Lace, White Satin and Chique – the five fragrances recently acquired from Yardley by Fine Fragrances & Cosmetics.

Distributor: Dendron.
Tel: 01923 229251.

Get a grip with new Wilkinson razor

Wilkinson Sword will be launching a new razor in the male super systems razor market in February.

FX Hypergrip is targeted at 16-24-year-old males. It features a ribbed grip handle designed to give improved control.

Retail price is £4.25.

Wilkinson Sword Ltd.
Tel: 01670 713421.

Let there be light

Philips has launched Original Bright Light in an attempt to banish winter blues.

Bright Light is a specially designed electrical light box which produces intense bright light of 2,500 LX. Sufferers of seasonal affective disorder and its milder form, referred to as winter blues, are thought to benefit from exposure to such light. Daily exposure of one to two hours is recommended initially.

As the appliance is portable, it can be placed on a table or desk while having breakfast, reading or writing. The light panel must be positioned to face the sufferer.

Bright Light has UV filters and meets European Medical Device approval. If eye irritation or headaches develop, the light can be dimmed to a more comfortable intensity. Dimmed down, it can also be used as an ordinary lamp. Use after 8pm is not recommended as it may affect sleep.

Bright Light comes in two models: HF 3300 which comes with a dimmer and retails at £199.99 and HF 3301 (without a dimmer) which retails at £169.99. Philips is distributing the appliance through Boots initially and has plans to introduce it to independent pharmacies later in the year.

Philips Home Appliances.
Tel: 0181 689 2166.

Massive eye opener from L'Oréal

L'Oréal will be introducing a new mascara in March. Le Grand Curl is designed to lift and curl lashes to create the effect of 'opening' the eye.

The formula contains a flexible protein complex with a high level of soft beeswax. The proteins wrap around the lash and hold it in place while the waxes dry to lock the curl.

The mascara brush is designed to apply the formula in a uniform layer with no extra deposits. Each bristle of the brush has a capillary channel extending from the base to the tip, which acts as a reservoir of mascara.

The product is ophthalmologically tested and suitable for sensitive eyes and contact lens wearers.

Le Grand Curl is available in black or brown. Retail price is £6.99.

L'Oréal.
Tel: 0171 937 5454.

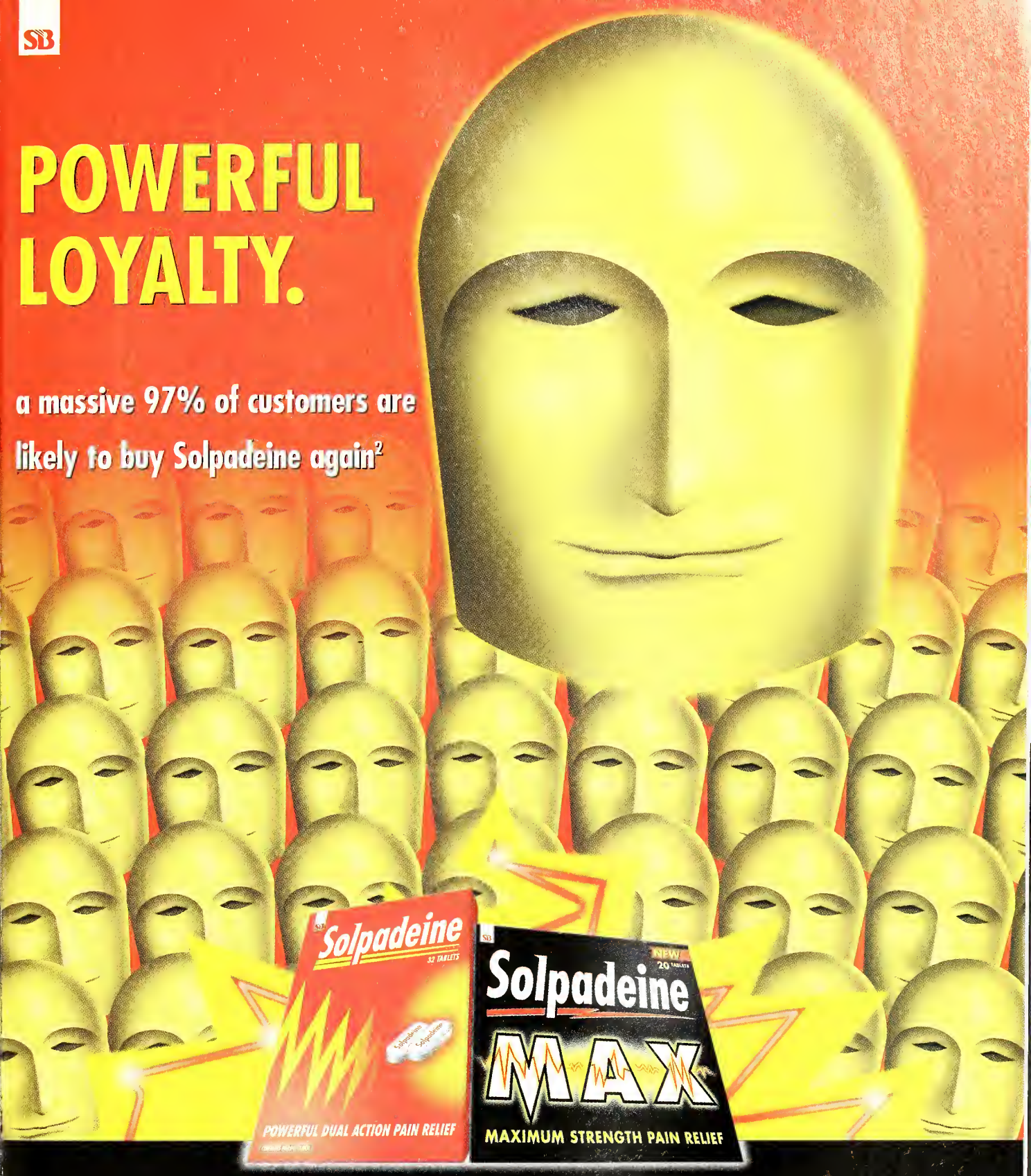
ON TV NEXT WEEK

Beechams Flu Plus Caplets: U
Canesten Combi: All areas except GMTV
Diflucan One: All areas except U
Imodium Plus: All areas
Just for Men: All areas
Meltus: G, Y, C, HTV, M, CAR, TT, GMTV, Sat
Niquitin CQ: All areas
Nizoral Dandruff Shampoo: All areas except U
Oilatum bath formula: C, M, CAR
Oilatum Junior: C, M, CAR
Poli-Grip: All areas except GMTV
Protector 3D: All areas except G, Y, GMTV, TSW
Strepsils: HTV, C4, C5, GMTV, Sat
Vaporub: G, C, HTV, M, CAR, TT, C4, C5, GMTV, TSW, Sat
Vaposyrup: G, Y, C, HTV, M, CAR, TT, TSW

A Anglia, **B** Border, **C** Central, **C4** Channel 4, **C5** Channel 5, **CAR** Carlton, **CTV** Channel Islands, **G** Granada, **GMTV** Breakfast Television, **GTV** Grampian, **HTV** Wales & West, **LWT** London Weekend, **M** Meridian, **Sat** Satellite, **STV** Scotland (central), **TT** Tyne Tees, **U** Ulster, **W** Westcountry, **Y** Yorkshire

POWERFUL LOYALTY.

a massive 97% of customers are likely to buy Solpadeine again[2]



Paracetamol, Codeine and Caffeine

Paracetamol and Codeine

Outstanding loyalty to Solpadeine

Salpadeine has the highest brand layalty af any OTC analgesic – 74%.[1] In addition, a massive 97% of custamers are likely ta buy Salpadeine again,[2] because it gives them what they want - pawerful and fast pain relief that they can trust.

Outstanding loyalty to you

And this brand layalty can wark far yau. Almast 9 aut af 10 custamers (88%) say they buy Solpadeine because it was recammended.[2] And wha has the mast influence an this decisian? Nane ather than their pharmacist.[2]

Which means that a simple recammendatian far the OTC analgesic that attracts the mast pawerful layalty af them all - Salpadeine, and Solpadeine MAX far Maximum Strength Pain Relief - can create the faundatians af pawerful layalty in yaur customers, and help yau graw yaur business. Remember, Salpadeine is the leading pharmacy analgesic, with a cash marhet share af 16.1%

THE **No.1** PHARMACY ANALGESIC

References 1 Taylor Nelson AGB Superpanel 1997 2 Taylor Nelson Sofres Healthcare 1998 3 IRI Infoscan, November 1998

SB SmithKline Beecham Consumer Healthcare

Script specials

IN BRIEF

Larger pack Naramig
Migraine treatment Naramig (naratriptan) is now available in a 12-tablet pack (basic NHS price £48).
Glaxo Wellcome UK. Tel: 0181 990 9000.

Codalax susp unavailable
The embargo placed on Regent GM Laboratories means that Napp's co-Codalax (co-danthramer) and Codalax Forte suspensions are temporarily unavailable. Supplies are expected to resume shortly. Capsule products are unaffected.
Napp Laboratories. Tel: 01223 424444.

Antabuse out of stock
Antabuse (disulfiram 200mg) will be unavailable until March owing to production difficulties.
Dumex Ltd. Tel: 01271 311200.

Varex bandage on Drug Tariff
Varex Short Stretch Bandage has been launched with a basic NHS price of £34.40 for an outer of 12.
Seton Scholl. Tel: 01565 624000.

Kaltostat and Aquacel on NHS
Kaltostat 2g rope and Aquacel 2 x 45cm will be available on the Drug Tariff from February (£15 for 5, and £11 for 5 respectively, basic NHS).
Convatec. Tel: 01895 628400.

Diamox Sodium parenteral
Diamox Sodium parenteral injection 500mg is out of stock due to hurricane damage to the factory in Puerto Rica. The problem is expected to continue until July. Wyeth will no longer be holding back orders.
Wyeth Laboratories. Tel: 01628 604377.

Cox co-danthrusate 50/6mg
Cox has launched co-danthrusate 50/60mg capsules in blister packs of 63 tablets (basic NHS price £13.46).
Cox Pharmaceuticals. Tel: 01271 311200.

Can no longer supply ...
Farillon says it can no longer supply Acthar Gel 80iu/ml, which has been supplied as an unlicensed medicine. Farillon will not commit to a date to resume supply and advises that patients be referred to their doctor for review.
Farillon Ltd. Tel: 01708 379000.

Humalog Mix25: insulin for advanced NIDD

Humalog Mix25 is the first rapid acting insulin mixture for people with type 2 diabetes mellitus.

Type 2 diabetes is also known as non-insulin dependent diabetes (NIDDM) and is usually controlled through diet, exercise and oral medication. However, in its advanced stage, natural production of insulin is diminished and patients need to turn to exogenous insulin. Humalog Mix 25 aims to target this group of patients.

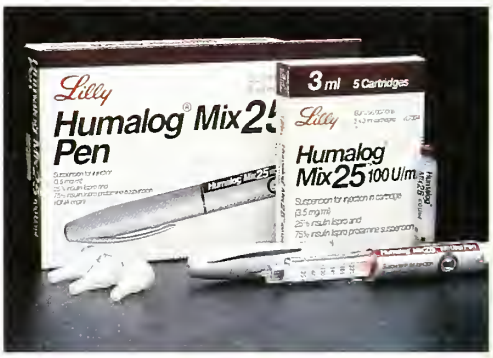
Humalog Mix25 contains 25 per cent insulin lispro and 75 per cent sustained release insulin lispro protamine suspension. As the insulin is rapid acting, it can be injected immediately before or after a meal to control blood sugar levels. With traditional, more slowly absorbed insulin mixtures patients have to wait for up to 45 minutes after injection before eating.

In trials, injecting Humalog Mix25 within five minutes of a meal resulted in significant improvements in post-prandial glycaemic levels over using human 30/70 insulin. The new insulin also produced significant reductions in nocturnal hypoglycaemia.

The UK Prospective Diabetes Study has recently shown that tight glycaemic control delays long-term complications.

Eli Lilly believes that making insulin injections simpler and more convenient will help people with Type 2 diabetes manage their condition better.

Humalog Mix25 comes in 3ml cartridges (5, basic NHS price £26.78) for use with Humapen, or in a 3ml prefilled disposable pen (5, £29.62).
Eli Lilly. Tel: 01256 315000.



MEDICAL MATTERS

You don't have to have SAD to see the light

People with winter blues, a milder form of seasonal affective disorder, can benefit from intensive light therapy.

Seasonal affective disorder (SAD) has been successfully treated with phototherapy since it was first recognised 15 years ago. However, 'winter blues' or sub-SAD has usually been overlooked.

Now Professor Chris Thompson, psychiatrist at the Royal South Hants Hospital, is saying that phototherapy can be extended to winter blues and need not be restricted to extreme forms of the condition.

Winter blues is characterised by lack of energy, a need for more sleep, irritability and a craving for carbohydrates. All these symptoms manifest themselves between November and March when daylight is limited.

SAD, on the other hand, is more debilitating, with regular cycles of depression. The benefit of phototherapy was demonstrated in a recent review of the literature which found that bright artificial light was twice as effective as dim light in alleviating the symptoms of the condition.

SAD affects between 0.5 per cent and 5 per cent of the adult population but when the spectrum is expanded to include winter blues, up to 25-30 per cent are affected.

Professor Thompson is about to start a study looking at how often GPs pick up on SAD and winter blues. The study is funded by a grant from Philips who has just launched a light appliance for the condition (see p10).

SAD is a serious condition defined by the World Health Organisation. It is thought to be caused by a decrease in serotonin in the hypothalamus and a consequent slowing down of the body clock.

Light therapy through visual stimulation helps to adjust this clock.

Coeliac disease underdiagnosed in the community

Coeliac disease is underdiagnosed and misdiagnosed in primary care leading to unnecessary ill health, according to new research.

The study in the latest *British Medical Journal* says that general practitioners often miss coeliac disease because of misunderstanding the symptoms and underusing serological tests.

Thirty patients with coeliac disease were investigated who had positive serological results for the disease. The diagnosis was confirmed with histological observation of the small intestine. The most common presentation was anaemia of varying severity and general non-gastrointestinal symptoms.

The authors comment that serological screening is a reliable diagnostic tool and suggest that it should be more widely used and better publicised in primary care so that more cases of coeliac disease can be picked up. Any warning signs such as anaemia or feelings of being 'tired all the time' should be investigated further, particularly where there is a family history.

The prevalence of the disease in Britain is thought to be higher than the estimated figure of 1:1000.

WHAT DO YOU DO IF YOUR CUSTOMERS ASK QUESTIONS

(THROW THE BOOK AT THEM)

Well it's not strictly speaking a book, it's the definitive pharmacy reference guide, which covers all aspects of oral care. If you haven't already received your copy of 'Taking the mystery out of oral care' there'll be one landing on your counter soon, so watch out! You'll also be receiving a merchandising package to encourage customers to ask about all aspects of oral care, and with the help of the guide you'll be able to give them all the answers they need. This guide is yet another demonstration of our commitment to both your customers' oral care and to you and your pharmacy. When your customers ask about sensitivity, recommend Sensodyne, the No1 toothpaste for sensitive teeth and gums.

potassium chloride, sodium fluoride, triclosan, strontium chloride

Prescribing Information. Presentations: Sensodyne: strontium chloride hexohydrate 5% in pink original flavoured and green mint flavoured dentifrice base. Sensodyne F: potassium chloride PhEur 3.75%, sodium fluoride PhEur 0.32% and triclosan 0.3% in white mint flavoured dentifrice base. Sensodyne Gel: potassium chloride PhEur 3.75%, sodium fluoride PhEur 0.32% and triclosan 0.3% in translucent blue gel mint dentifrice base. **Uses:** Sensodyne: Relief from the pain of dentinal sensitivity. Sensodyne F and Sensodyne Gel. Relief from the pain of dentinal sensitivity, an aid for the prevention of dental caries and contains an antimicrobial agent with proven anti-gingivitis activity. **Dosage and Administration:** To be used 2-4 times daily in place of regular toothpaste. **Contra-indications, warnings etc:** Sensitivity to any of the ingredients. Sensitive teeth may indicate an underlying problem which needs prompt care by a dentist. See your dentist as soon as possible for advice. **Packaging quantities:** Sensodyne: tubes of 45ml and 75ml. Sensodyne F: tubes of 45ml and 75ml. Pump dispenser of 100ml. Sensodyne Gel: tubes of 45ml and 75ml. **Cost:** (Trade price per dozen) 45ml £16.69, 75ml £28.25, 100ml £36.15. **Legal Category:** GSL. **Product licence nos:** Sensodyne Original PL00036/5011R, Sensodyne Mint PL00036/0055R, Sensodyne F PL00036/0085, Sensodyne Gel PL00036/0086. Further information is available from Stafford-Miller Ltd, Broadwater Road, Welwyn Garden City, Herts AL7 3SP. Tel: 01707-331001. Date of revision: July 1997. Sensodyne is a trademark of Stafford-Miller Ltd.

STAFFORD-MILLER

From Numark – just for the record

For the record, I would like to make the following points:

- Numark Ltd is an industrial and provident society owned by community pharmacists, and the first responsibility of the directors is to its shareholders – community pharmacists. All decisions are based on what is in the best interests of the shareholders, both for the short and the longer term. In coming to such decisions, due consideration is given to its trading partners, in particular, the wholesale distributors.
- Times are changing and will continue to do so. There has been substantial consolidation of both wholesale and retail ownership and that will continue. In its history, Numark has worked with virtually every wholesaler, including AAH (now owned by Gehe). I wish to emphasise that Numark does treat all of its wholesalers on an equal basis, showing favour to none.

A benefit of the link with UniChem is to maintain the freedom of choice for shareholders to select the Numark wholesaler of their choice. Many shareholders demonstrate their commitment to Numark by using two Numark wholesalers, one as first line and one as a second line.

- The reality is that there are now three pan-European wholesalers operating in the UK together with the regionals. That there will be more change is not in doubt. The Numark decision acknowledges a changing world whilst maintaining its moral and legal obligations to its wholesale distributors and shareholders.
- All pharmacists, including Numark shareholders, have to deal with tremendous change and competition. There is more change to come from the NHS; information technology is moving rapidly and there will be other changes as yet unknown. Numark has the ability to assist its shareholders to deal with such changes and, just as important, to empower them to become equal partners in managing change.
- The two wholesalers recently acquired by Phoenix – L Rowland & Co Ltd and Philip Harris Medical – remain Numark distributors, which was at their request and welcomed by Numark. Additionally, discussions with UniChem started back in the summer last year, well before we were aware of the Phoenix development.
- With regard to the longer term, I may have a personal vision and whether it can be achieved, or is worthy of achievement, will be decided by pharmacists at some future date. Numark Ltd has no immediate plans for major European expansion other than its existing relationships in the Republic of Ireland.

There is much to be done in the UK to make the existing business stronger and better able to support independent community pharmacy in facing a challenging future. That is our *raison d'être* on which I am sure *Chemist & Druggist* can agree.

Just a small correction: Numark has a a target to reach 2,000 pharmacies – not members – although I do appreciate your positive thinking!

Terry Norris
Managing director, Numark

Present *and* future Numark distributors

It was with great interest that we read **Comment** and **Business News** last week about developments at Numark and its distribution network.

Your **Comment** was particularly stimulating, and it was a pleasure to see, once again, informed opinion from *Chemist & Druggist* on the changing world of pharmacy.

There was one error that does require correction, however. You refer to "Phoenix acquiring two former Numark distributors". The Numark distributors acquired by Phoenix, namely Philip Harris Medical and L Rowland & Co, are certainly not 'former' Numark distributors. We are present and future Numark distributors, and are both strongly committed to providing the highest standards of service to Numark shareholders.

May we remind your independent pharmacy readers that we would welcome the opportunity to discuss the considerable benefits of Numark membership with them. We shall be speaking from experience – all our community pharmacies are among the 1,200 that are proud to be Numark pharmacies.

Roger Brown
Sales & marketing director, Philip Harris Medical

Argument against GSL gum goes up in smoke

I write in response to the **Xrayser** article in your January 9 issue – 'GSL gum spells out bad news for the health of the nation' – where your columnist argues that nicotine gum is a route to subsequent tobacco addiction.

There is, quite simply, no evidence to support this claim, but there is a substantial body of evidence that the reverse is true. In those countries where nicotine replacement products have been made more widely available, the number of quit attempts and the number of successful quit attempts is shown to increase. This has to be good news.

Smoking is by far the largest preventable cause of premature death in the country. Pharmacists have a crucial role to play in tackling this problem – as do all health professionals. However, the problem is far too big for any of us to feel we can solve it alone.

Xrayser accuses those who supported the consensus statement on 'The Benefits to Public Health of Increased Availability of Nicotine Replacement Therapy', produced by the Imperial Cancer Research Fund, of being naive. Is it naive to dispassionately examine the evidence and reach a conclusion based on what is in the best interest of smokers?

QUIT counsels nearly half a million smokers a year. This provides us with a unique insight into the problems they face and an understanding of their needs. Our position on the GSL status of 2mg gum has been determined by our desire to help more people stop smoking and no other.

One final thought. Where do quitters go to ease their cravings after the High-Street pharmacy has closed? They can phone the Quitline but they may need counselling and NRT. Do they search around and look for a late-night pharmacy? Or do they abandon their quit attempt and go to the nearest cigarette machine, garage or off licence, only to perpetuate their potentially lethal habit?

Peter McCabe
Chief executive, QUIT

Exclusive only for as long as it lasts ...

Your news story on the distribution deal between SurgiChem and Pro-Choice Applications for the new Nomad for Windows program (last week p41) has prompted a number of calls from customers concerned that their software companies might be excluded from using the program.

The simple answer to this is 'no'. While PCA is the first to enter into such an agreement with us, the program will be available to other software houses.

But, as PCA will be launching the program in the early spring, its users will be the first, and at that time the only pharmacists in the UK to benefit from it. Thanks to the Nomad/PCA interface we have developed, they will be able to access information for Nomad directly from their main pharmacy database.

Clearly we are delighted to be working with PCA in this way. If other software companies would like to extend these benefits to their users, we will be happy to work with them, too.

Norman Niven
Chief executive, SurgiChem

Pop art signage is one of the different features in a new pharmacy opened by United Norwest Co-op in Freeport Outlet Mall in Talke, near Stoke-on-Trent. The outlet has a highly visible dispensary and perfume displays, set in special cabinets facing the mall

WARNING!

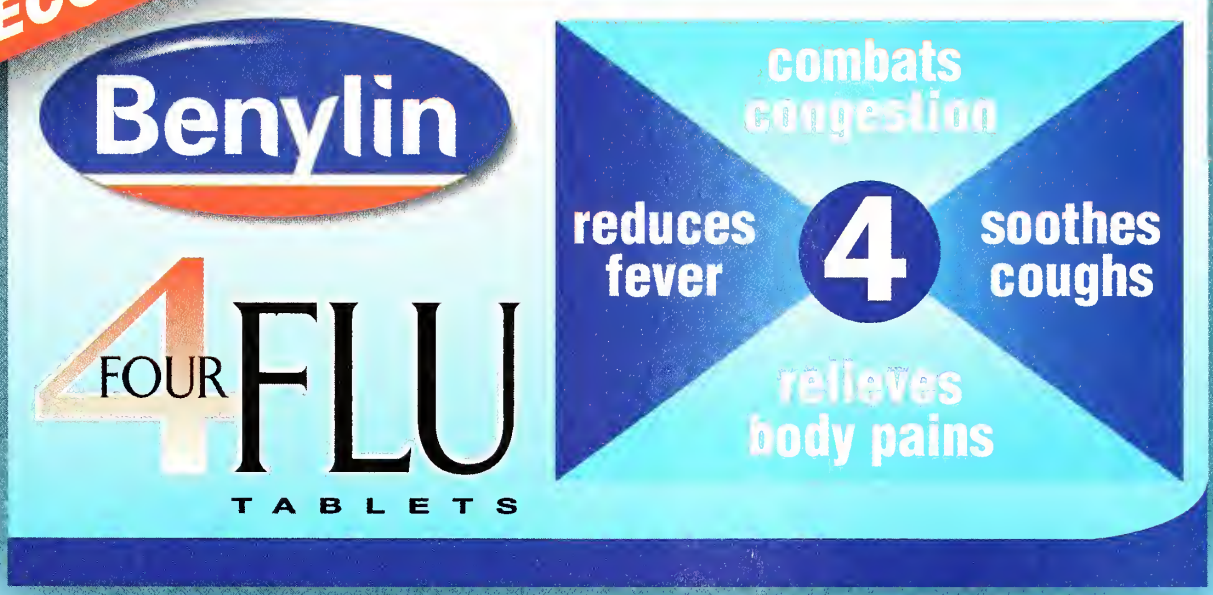
NHS Hospitals stretched to breaking point

Millions of working days lost to flu bug

FLU OUTBREAK SWEEPS UK

Cold & Flu Outbreak Lays Britain Low

RECOMMEND



Diphenhydramine, Paracetamol, Pseudoephedrine

- Unique four-way action formula
- Complete range of formats

POWERFUL RELIEF FROM THE FOUR MAIN SYMPTOMS OF FLU

Benylin 4Flu
Presentation: 4 Flu Tablets: Orange film coated tablets containing 12.5 mg Diphenhydramine hydrochloride, 500 mg Paracetamol and 22.5 mg Pseudoephedrine hydrochloride per tablet. 4 Flu Liquid: Orange liquid containing 25 mg Diphenhydramine hydrochloride, 1000 mg Paracetamol and 45 mg Pseudoephedrine hydrochloride. **Uses:** relief of symptoms associated with colds and flu; including coughing, fever, headache, muscular aches and pains and congestion. **Dosage:** Tablets: Adults: 2 tablets four times daily; children aged 6 - 12 years. 1 tablet four times daily; children under 6 years: not recommended. Liquid: Adults: 20 ml four times daily; children aged 6 - 12 years 10 ml four times daily; children under 6 years: not recommended. **Contra-indications:** Known hypersensitivity, severe hypertension or severe hyperthyroidism. **Precautions:** Caution in patients with cardiovascular disease, hypertension, hyperthyroidism, prostatic enlargement, liver disease, renal disease, glaucoma or diabetes. Do not take with any other paracetamol containing products. May cause urinary retention in patients with prostatic hypertrophy. May cause drowsiness, if affected do not drive or operate machinery. Avoid alcohol and drugs with anti-cholinergic properties. Caution during pregnancy. **Side and adverse effects:** Occasionally skin rash, nausea, headache, dizziness, sedation, tachycardia and insomnia may occur. **Price** (ex-VAT): Tablets: 24s £3.39. Liquid 200 ml £3.73. **Legal category:** P. Further information is available from: Warner Lambert Consumer Healthcare, Chestnut Avenue, Eastleigh, SO53 3ZQ. **Product licence number:** Tablets: 15513/0058. Liquid: 15513/0057. **Date of preparation:** January 1999.

Radian B. Now backed by a national TV campaign.

A new look Radian B is now appearing on shelves across the country. But we're not stopping there. From February, we'll be displaying our modern, eye-catching look on the nations TV screens as well as across the pages of its magazines and newspapers.

Based on extensive consumer research and with over £1million worth of muscle behind it, the campaign is set to push Radian B to the forefront of the topical analgesic market.

Add to that, new in store support, and we think you'll give Radian B some strong backing of your own.

Norton issues patient leaflet diskette

Norton Healthcare has sent a computer diskette containing product information leaflets (PILs) to all registered pharmacies.

The diskette is intended to allow pharmacists to dispense Norton products in line with the patient pack initiative, which came into effect on January 1, in line with European Directive EEC/92/27.

PILs can be printed off and given to patients, or the disk used as an information source, says Norton. However, the PILs only apply to Norton products, not to those in different liveries but with a Norton product licence.

Norton has used the lowest version of Word available, so that any pharmacies with Word software should be able to access the information. However, it will require a Windows-based system. The company is also producing surplus leaflets which should be available through normal distributors if pharmacists require them.

Although guidance issued by pharmacy bodies last month advised that pharmacists should continue to dispense as they did in 1998 if they cannot get patient packs, "they may need to show that they have made every effort to obtain and/or dispense a medicine with the appropriate leaflet and label", says Norton.

The Medicines Control Agency could enforce the directive at any time but, with only six inspectors, it would be difficult to do so overnight, argues Norton's trade marketing manager, Richard Saynor.

"While pharmacists and companies are being shown to make best efforts to comply, it should be OK," he said. As such he hopes the diskette will help pharmacists cope with the regulations until a patient pack scheme is finally approved by the Government.

At present, Norton has 70 per cent of its 350 products in patient packs, but leaflet and label text has been approved for 93 per cent of its product range.

Any pharmacy which did not receive a copy of the diskette and would like one should contact Norton Healthcare on 08705 020304.

Food Commission gets tough on medicine additives

The Food Commission is calling for tighter labelling controls on OTC medicines, after a survey found undeclared additives and contaminants which are banned in food.

The Commission was 'alarmed' to find that some medicines and supplements failed to declare all their ingredients, and others included unexpected animal and insect-derived ingredients, artificial sweeteners, synthetic colourings or high levels of sodium.

An article in *The Food Magazine*, published by the Commission, calls for a review of the approval arrangements for non-nutritive additives.

The article asks whether Resolve and Rap-eze need to be coloured with coal tar dyes, or whether Redoxon needs to be coloured with erythrosine, which is banned from most foods. People trying to reduce their salt intake might not realise that sodium comes in other forms such as sodium bicarbonate in effervescent tablets.

The magazine also lists products containing additives derived from insects, such as cochineal in Bassett's Soft and Chewy vitamins and Sanatogen one-a-day multivitamins and iron. Shellac, "made from resinous secretions of insects", was found in Minadex chewable children's vitamins, Redoxon slow-release vitamin C, Kwai garlic tablets, Höfels Cardiomax and Seven Seas minerals for bones.

Manufacturers are criticised for not always making it obvious when products are unsuitable for vegetarians, for example, if they contain gelatine, stearates or glycerol which can be derived from animal sources.

Dr Tim Lobstein, the Commission's co-director, says that medicines such as Lemsip and Resolve have been sweetened first with sugar and then with artificial sweeteners.

"Beechams All-in-one contained three sweetening agents, two artificial colourings and alcohol, while Tums is principally made of chalk with added sugar, starch, flavouring and four artificial colours - and costs £30 per kilo!" he comments.

Radian-B Muscle Lotion Presentation: Lotion containing (w/v) menthol (1.4%), camphor (0.6%), ammonium salicylate (1.0%), aspirin 1.2%, salicylic acid (0.54% as methyl and ethyl esters). **Uses:** Symptomatic relief of muscular and rheumatic aches and pains, including: fibrositis, sciatica, lumbago, sprained ligaments, bruises, muscle stiffness, strains, tennis elbow, golf shoulder. **Dosage and administration:** Dosage: Sprinkle on the affected part once or twice, leaving 10-15 minutes between applications, up to three times daily. **Warnings and precautions:** Contraindications: Not to be used on children under 12 years old, and not to be applied to skin abrasions, or irritated skin. Precautions: Keep away from eyes and other sensitive areas. Side effects: If used on tender skin do not cover immediately after application. If an adverse reaction occurs, discontinue use immediately. Use in pregnancy/lactation: Not to be used. **Prices** £2.46 and £6.12 (11/98)
Legal category GSL **Product Licence number** 0031/0352 **Product Licence Holder:** Roche Consumer Health, 40 Broadwater Road, Welwyn Garden City, Hertfordshire AL7 3AY
Date of preparation: 30/11/98.

Radian-B Anti-Inflammatory Ibuprofen Gel Presentation: Gel containing 5% w/w ibuprofen. **Uses:** Backache, rheumatic and muscular pain, sprains, strains and sports injuries. **Dosage and administration:** For adults and children over 14: Squeeze 50 to 125mg of the gel and lightly rub into affected area. Do not repeat application more frequently than every four hours and no more than 4 times in any 24 hour period. Wash hands after application. Not for children under 14. **Warnings and precautions:** Contraindications: Hypersensitivity to constituents, hypersensitivity to aspirin or other NSAIDS, asthma, rhinitis or urticaria. Interactions: Concurrent use of aspirin or other NSAIDS may result in an increased incidence of adverse reactions. Precautions: Avoid contact with eyes, mucous membranes and inflamed or broken skin. Discontinue use if rash develops. Not for use with occlusive dressings. Side effects: Application site reactions, rashes, pruritis, urticaria, abdominal pain, dyspepsia and bronchospasm. Avoid use during pregnancy, (the onset of labour may be delayed and duration of labour increased). Ibuprofen appears in breast milk at very low concentrations. **Prices** £3.39 (11/98)
Legal category GSL **Product Licence number** 0031/0496 **Product Licence Holder:** Roche Consumer Health, 40 Broadwater Road, Welwyn Garden City, Hertfordshire AL7 3AY
Date of preparation: 25/02/97.

Radian-B Muscle Rub Presentation: Cream containing (w/w) menthol (2.54%), camphor (1.43%), methyl salicylate (0.42%), and oleoresin capsicum (0.005%). **Uses:** Symptomatic relief of aches and pains, including muscular stiffness, bruising, sprains, fibrositis. **Dosage and administration:** Apply to the affected parts and slowly massage well into the skin. **Warnings and precautions:** Contraindications: Not to be used on children under 6 years old, and not to be applied to skin abrasions, or irritated skin. Precautions: Keep away from eyes and sensitive areas. Side effects: Use sparingly on tender skin and do not cover immediately after application. If an adverse reaction occurs, discontinue use immediately. The presence of menthol may cause contact dermatitis or eczema, and hypersensitivity reactions characterised by urticaria, flushing and headache. Use in pregnancy only when there is no safer alternative. Use in lactation is acceptable. **Prices** £1.61, £2.88 & £14.88 (11/98) **Legal category** GSL **Product Licence number** 0031/0354 **Product Licence Holder:** Roche Consumer Health, 40 Broadwater Road, Welwyn Garden City, Hertfordshire AL7 3AY
Date of preparation: 25/02/97.

Radian-B Pain Relief Spray Presentation: Spray containing (w/v) menthol (1.4%), camphor (0.6%) ammonium salicylate (1.0%), salicylic acid (0.54%) as methyl and ethyl esters. **Uses:** Symptomatic relief of muscular and rheumatic aches and pains, including: fibrositis, sciatica, lumbago, sprained ligaments, bruises, muscle stiffness, strains, tennis elbow, golf shoulder. **Dosage and administration:** Dosage: For adults and children over 12: Spray as required. Second application after 10-15 minutes. Repeat application up to three times daily, reducing to morning and evening when acute symptoms subside. Children under 12: Not recommended. **Warnings and precautions:** Contraindications: Do not apply to skin abrasions, or irritated skin. Hypersensitivity to ingredients. Precautions: Do not use near the face, eyes and other sensitive areas. Side effects: If used on tender skin do not cover immediately after application. Use in pregnancy/lactation: Not to be used. **Prices** £2.03 (11/98) **Legal category** GSL **Product Licence number** 0031/0353 **Product Licence Holder:** Roche Consumer Health, 40 Broadwater Road, Welwyn Garden City, Hertfordshire AL7 3AY **Date of preparation:** 25/02/97.

The clawback which each pharmacy faces is based on averages. So, to an extent, is prescription reimbursment. Can you be sure the system is treating you fairly? A senior pharmacy manager has his doubts ...

'Average' does not exist

The average family comprises two parents and 2.4 children. There is, therefore, no such thing as the average family. The average life expectancy of the UK population is 69 years for men and 73 for women.

Of course, your average life expectancy will be somewhat higher than this, whatever your gender, since you have made it this far already.

The pages of the pharmacy press have been awash recently with comment on the imposed clawback, which is set to remove an average £6,000 from the income of the average contractor over the next year. Within the averaging must lurk considerable injustice.

The average pharmacy has an average net ingredient cost (NIC), and this could be widely different from the NIC of the individual business you or I might be looking at. Information from the Department of Health statistical bulletin reveals just how different the NICs can be when comparing the averages from prescriptions in individual health authority areas.

Pretty good NIC?

And, since these are averages, the swings and roundabouts between any pharmacy in, say, Sheffield (average NIC in 1997, £7.27) and one in, say, East & North Hertfordshire (average NIC in 1997, £10.75) could be great indeed.

Then, if your GPs (or their practice pharmacist) are not big fans of ranitidine, or are into generics big time, there is another complicating factor which could take you away from being anything like average.

There are still pharmacists around who set their face against the use of parallel imports, in spite of the inclusion of PIs within the clawback system. If this is you, or if you haven't used your share over the past year, then that's tough, because you will be clobbered just the same.

So, if you are in a low NIC, high generic, high ranitidine area and use loads of PIs, it could have been a lot worse. But if you have high NIC, with GPs who use nizatidine, and you don't use PIs on principle, then the Government would like to tell you that your purchasing strategy is not efficient enough.

This simple consideration of how dramatic the impact of the averaging system can be on individual pharmacy incomes has led me to some further thoughts.

Given that the clawback is based on an averaging system, and a complicated one at that, and looking at the discrepancies I see reported month after month to local pharmaceutical committees by the PSNC's National Prescription Research Centre, how far can we trust the authorities to get our prescription payments right?

The right piles

I am sure that many contractors do not fully appreciate the value of the prescriptions they submit each month. Given the numbers of scripts now being dispensed, can anyone put their hand on their hearts and say, month after month, that they know for certain how many scripts they have submitted, and that they have been submitted in the right piles?

Given the paucity of information on the FP34 (compared to the huge amount of information provided to GPs who don't have thousands of pounds invested in the medicines in the first place), how do we know that the remuneration and reimbursement calculations are right?

You might argue that we have nothing to worry about. After all, the Prescription Pricing Authority performs its own in-house audit and the results are taken into account when the discount scale is calculated. But once again that is an average, and if its your £250 that is short, it is not much comfort to you as you juggle cashflow.

To look at just one other line on the FP34: are you sure the number of prescription charges the PPA reckons you collected is the number you put in your till? Judging from the number of LPCs that are currently questioning the PPA on prescription exemption calculations (Liverpool featured in these pages recently), I suspect I am not alone in wondering whether we are taking trust a little too far.

A recent problem prompted me to question this aspect of PPA procedure. Apparently, if you miss getting one or two prescriptions filled in properly by the patients - perhaps they fail to sign properly to claim exemption - they can get treated as chargeable.

But here's the rub. Unless there are a large number of these, you won't even know, because the PPA won't necessarily tell you.

Dim view

Quite rightly, the PPA takes a dim view of gross errors, for example when scripts from a nursing home are submitted without signatures. But should this dim view be reflected in the kind of penalties that are imposed for what are relatively minor transgressions?

At £5.80 per item, a small number of prescription forms per month can quickly add up to hundreds of pounds.

If the problem occurs because pharmacy staff failed to complete, to the perfect satisfaction of the PPA, prescriptions for housebound patients where full prescription management is undertaken by the pharmacy without payment, the penalty seems particularly harsh.

To add insult to injury, at the moment there is little recourse, except to involve the health authority in retrieving the forms and arguing it out with them.

If this were not bad enough, the number of ways in which a prescription can be incompletely filled is about to increase, as exemption checking comes in. So things can only get worse.

Still content to be averaged?

PHARMACY update

Taking the pressure

Hypertension is one of the most common causes of death and disability. Pharmacist Jean Rothwell investigates the problem

Cardiovascular diseases are the most common cause of deoth ond disability and hypertension is the leading couse of mortality in the world, after malnutrition and tobacco use. It is responsible for an estimated 5.8 per cent of all deoths. Nowadays, the availability of effective ontihypertensive ogents has brought about a significant reduction in cordiovascular events.

Nevertheless, it is thought that only a minority of potients being treated with drugs for hypertensive disease ore sotisfoctorily controlled. The main problems appeor to be side effects and non-compliance. As newer medicines become avoiloble with fewer side effects and once-daily doses, it is expected thot compliance will improve in future years.

Extent of the problem

Most people suffering from raised blood pressure are unaware of their problem and it is often called a 'silent killer' because sufferers usually do not feel unwell and have no clinical symptoms. However, because hypertension increases the chonces of the person suffering o stroke or of developing heart or kidney disease, it is advisable for medical checks to be carried out periodicolly to detect hypertension as eorly as possible. This is important in coses of people most likely to be affected – for exomple, smokers, the middle-oged, the elderly or the overweight, as screening is the only reliable way of detecting hypertension.

There is no strict dividing line between 'normal' and 'high' blood pressure – the World Health Organisation defines hypertension in people over the age of 65 years as having a blood pressure reading consistently exceeding 160mm Hg (systolic) and 95mm Hg (diastolic).

Most adults have a systolic pressure of between 100 and 140mm Hg and a diastolic pressure of between 60 and 90mm Hg. Hypertension is diagnosed if both the measurements are consistently elevoted above whot might be considered normal for the particular age group.

Systolic pressure is the pressure coused when the blood surges into the aorta from the heort; diastolic pressure is the pressure produced when the ventricles relax between beats. There is a lot of individual variation in blood pressure readings which are affected by factors such as the time of day, activity, age and general health of the person concerned.

Pressures that are raised above 140/90mm Hg on several successive readings could indicate diseose and pressures slightly above this would constitute mild hypertension. It is thought that between 10 and 20 per cent of people in the UK suffer from high blood pressure. The condition is more common in men than in women ond its incidence is highest in the middle-aged and elderly, although young adults can also be hypertensive. Over 5 per cent of men ond women over the oge of 65 have a systolic and diastolic blood pressure greater than 200/100 mm Hg.

Further foctors must be taken into account, such as the fact that average blood pressure rises gradually throughout life because the walls of the orteries become less elastic with age. Even o small increase in rigidity can greatly increase blood pressure so thot what is 'normal' for a 70-year-old would be obnormal for someone of 20. Young children usually have blood pressure readings well below the readings for the overoge adult.

Since new drugs have become available for the treatment of hypertensive heart disease over the past 30 years, the death rate from hypertensive disease hos follen by over 75 per cent in both men and women between 1958 and 1984.

Continued on PII →

Occupational stress may increase the risk of essential hypertension

THE COLLEGE OF PHARMACY PRACTICE

THIS COURSE (MODULE 1115), IN ASSOCIATION WITH MULTIPLE CHOICE QUESTIONS BEING PUBLISHED IN *C&D* FEBRUARY 13, PROVIDES ONE HOUR'S CONTINUING EDUCATION

OBJECTIVES

- To be aware of the definition of hypertension
- To understand the causes of hypertension
- To recognise complications of untreated hypertension
- To recognise treatment regimens
- To be aware of lifestyle influences

Endocrine disorders

The adrenal glands may sometimes be affected by the growth of a tumour resulting in an increased production of adrenalin. Blood pressure may suddenly rise to 220/140mm Hg and the tumour must be removed. The tumour is known as a phaeochromocytoma. Conn's syndrome – an adenoma of the adrenal cortex or hyperplasia of the normal cells – produces large amounts of aldosterone, this causes the blood pressure to be raised by preventing the kidney from removing salt and water from the blood.

Continued from PI

Secondary hypertension

In some cases – about 10 per cent – the cause of hypertension is identifiable, eg the use of oral contraceptives, NSAIDs, endocrine disorders, renal artery stenosis, obstructive renal disease, over production of aldosterone and Cushing's syndrome. This is called secondary hypertension.

Essential hypertension

Where there is no obvious cause for high blood pressure – in approximately 90 per cent of patients – people are said to be suffering from essential hypertension. Factors associated with an increased risk of essential hypertension include smoking, obesity, excessive alcohol intake, a family history of hypertension, a sedentary lifestyle and a high degree of social or occupational stress.

Causes

Hardening of the arteries – arteriosclerosis – is the most common cause of hypertension. The arterial walls lose some of their elasticity, causing the peripheral resistance to rise and the heart to work harder to pump blood. Arteriosclerosis can cause problems, but it is not considered to be serious unless the systolic pressure rises to 200mm Hg or more.

Atherosclerosis – a form of arteriosclerosis – often causes hypertension, as cholesterol and other fats are deposited on the inner lining of the arteries. The arteries become narrower causing the heart to work harder to force the usual volume of blood through them.

Smoking aggravates the effects of hypertension resulting in atherosclerosis, coronary artery vasoconstriction and sudden cardiac death. It can also inhibit the antihypertensive effects of drugs such as propranolol and calcium channel blockers.

Smoking doubles the risk of developing heart disease and trebles the chance of a person dying before reaching retirement. By giving up smoking, many people will reduce their chances of developing hypertension.

Other causes of essential hypertension may be linked to genetic or environmental factors. These can be adjusted. For example, reducing excessive intake of alcohol, particularly when consumption is more than 20 units per week; advising overweight people to try and reduce weight; and, for those with a high salt consumption, reducing the daily intake of salt – too much salt can affect blood pressure.

The more serious problems of hypertension begin when both the systolic and diastolic pressures remain high. As the muscles of the left side of the heart have to work harder pumping the blood, the heart becomes enlarged and may weaken to the extent that same degree of heart failure results. Arteries also have to bear the strain and occasionally one ruptures. If this happens in one of the small arteries of the brain, the result is a cardiovascular accident or stroke.

Complications of hypertension

Apart from a cerebral haemorrhage, stroke can also be caused by a cerebral thrombosis when a clot forms which partially or totally blocks an artery that may already have been narrowed by atherosclerosis. A cerebral embolism is a small clot formed elsewhere in the bloodstream that is carried along by the blood until it similarly obstructs an artery leading to the brain.

Hypertension is a major risk factor for heart failure and plays a key role in the development of the disease. Early treatment of hypertension reduces the risk of progression to heart failure. It is important that a close watch is kept on the other risk factors associated with cardiovascular disease. In addition to hypercholesterolaemia, there is a risk of hyperglycaemia developing in hypertensive patients of both sexes, particularly older patients if they are smokers. By giving up smoking they may avoid the development of diseases such as diabetes.

If hypertension is left untreated a person may suffer various consequences, for example, a stroke, heart attack, uraemia, aneurysm etc. In pregnant women hypertension may lead to haemorrhage, eclampsia, retarded growth or possibly the death of the foetus.

When diagnosing hypertension the patient's blood pressure is measured several times and if consistently high readings are shown on three occasions, other symptoms are considered. The back of the eye may be examined with an ophthalmoscope for signs of hypertensive retinopathy, a complication of hypertension which is characterised by a narrowing of the retinal arteries. Areas of retina may be destroyed, and haemorrhage and white deposits may occur in the retina. Such evidence gives a reason for starting the patient on a course of antihypertensive treatment. When the diagnosis of high blood pressure has been made, a suitable programme of treatment must be drawn up from the wide choice of treatments available.

Treatment

Diuretics

Several types of diuretics are available for the treatment of hypertension. The main ones are:

1 Thiazides bendrofluazide, hydrochlorothiazide

2 Loop diuretics frusemide

3 Potassium sparing diuretics amiloride, triamterene, spironolactone.

Many hypertensive patients are initially treated with thiazide diuretics, which are selected because of their effectiveness and low cost – bendrofluazide being a popular choice. By increasing the excretion of water from the kidneys, the blood volume is lowered and hence the blood pressure. The usual starting dose of bendrofluazide is 2.5mg daily. Some patients may suffer side effects caused by an upset in their body's metabolism when potassium is lost from the body after taking a non-potassium sparing diuretic such as bendrofluazide.

When blood levels of potassium fall, patients may feel weak, dizzy or sick and their potassium levels should be checked and suitable changes made in the choice of diuretic used or a potassium supplement added to their medication regime. Eating foods of a high potassium content, eg bananas, also helps. An alternative choice may be a loop diuretic which prevents reabsorption of water and sodium, and can be used when there is renal impairment. Frusemide, a loop diuretic, induces effective diuresis but it is a less effective antihypertensive agent than bendrofluazide.

Beta blockers

Beta blockers are effective in the treatment of hypertension, as they reduce the risk of stroke and myocardial infarction. They also reduce the rate at which the heart works and hence the blood output. They relax smooth muscle in the arteries which reduces the peripheral resistance to blood flow, and they also reduce cardiac response to stress and exercise.

Beta blockers should not be used for patients suffering from asthma, chronic bronchitis, emphysema or other respiratory diseases because they may narrow the airways in the lungs. Where there is an indication that a beta blocker is the preferred drug, it is important for additional treatment to be available, eg an inhaler, to deal with any breathing problems that might arise in affected patients. Beta blockers slow down the heart rate, which means less oxygen is required. This may produce adverse reactions in cases of heart failure or heart block. They also reduce the flow of blood to extremities causing patients to suffer cold hands and feet.

A combination of diuretics and beta blockers remains the first

Continued on PIV →

Special cases in hypertension

Certain groups of patients may benefit from having specialist attention.

These include:

a) **Elderly people** Those over the age of 65 years who have an isolated systolic pressure of greater than 180mm Hg run the risk of suffering a stroke. These people benefit from having their treatment reviewed at regular intervals. If they suffer from other conditions eg asthma, cardiac failure or peripheral vascular disease, nifedipine is probably the drug to use but not a beta blocker or verapamil. Methyldopa is also an alternative choice for such cases, if nifedipine is not considered suitable for their treatment.

b) **Pregnant women** Special precautions are needed in the treatment of pregnant women to avoid any risk to the foetus. Methyldopa should be considered. Use of a beta blocker is not advised before the third trimester; ACE inhibitors are contra-indicated because of adverse effects on the foetus and calcium blockers are not licensed for use in pregnancy.

c) **Diabetic patients** People suffering from diabetes mellitus frequently also suffer from hypertension. These patients should not be treated with beta blockers or thiazide diuretics. Beta blockers interfere with the metabolic response to hypoglycaemia and thiazide diuretics can cause hyperglycaemia.

d) **Depression** ACE inhibitors, calcium blockers and diuretics are appropriate drugs for the treatment of depressed patients. Beta blockers can cause lethargy and should be avoided in these patients.

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Date of Preparation: December 1998

Continued from PII

choice of drug therapy in most patients for the treatment of hypertension. If this treatment is contra-indicated or ineffective, other types of drugs are available (see below).

ACE inhibitors

Angiotensin converting enzyme (ACE) inhibitors block the conversion of angiotensin I to angiotensin II which is released from artery walls. Angiotensin II has a vasoconstrictor action, stimulating the synthesis and release of aldosterone which reduces the extraction of salt and water from the blood.

Ace inhibitors are generally well tolerated. Side effects include 'first dose hypotension', cough and renal impairment in patients with bilateral renal artery stenosis or renal artery stenosis to a single kidney.

ACE inhibitors can be used with some diuretics but not generally with potassium sparing diuretics as ACE inhibitors also keep potassium in the body.

Angiotensin II antagonists

A newer group of related medicines called angiotensin II antagonists attempts to prevent angiotensin II binding to its receptor rather than inhibiting its formation.

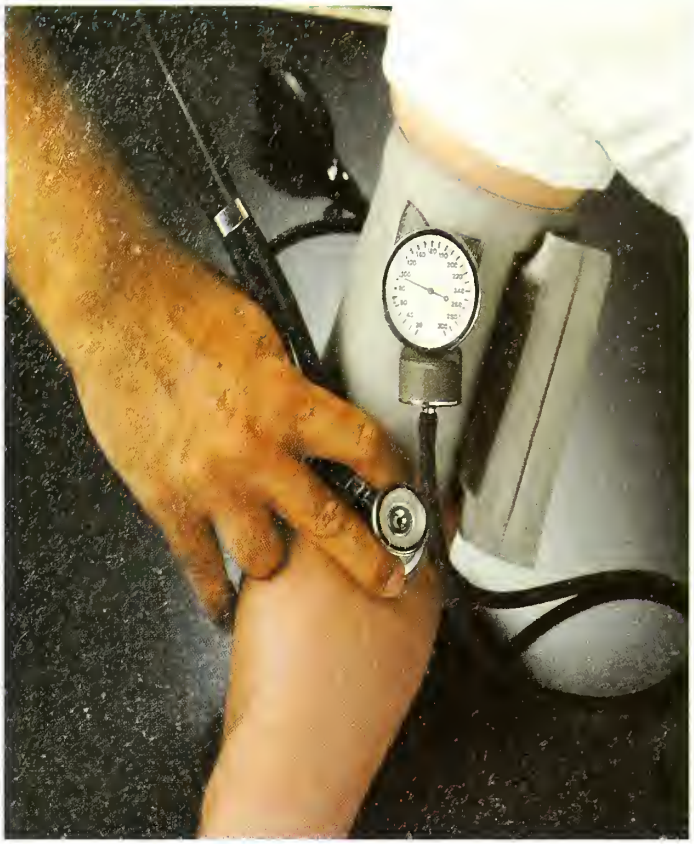
Angiotensin II antagonists which work to lower blood pressure through blockade of the renin-angiotensin-aldosterone system. It is reported that losartan's greater selectivity of action reduces some of the adverse reactions associated with ACE inhibitors, particularly the dry cough.

Calcium channel blockers

Calcium antagonists interfere with the flow of calcium through channels in the cells of the heart and the smooth muscle of blood vessels to relax them. Calcium is essential for the proper functioning of muscles and, unlike beta blockers, calcium antagonists can be used for the treatment of hypertension in asthmatics.

ACTION PLAN

1. List in your practice workbook food sources of potassium
2. Look at medication records of patients on beta blockers. How many have been prescribed salbutamol inhalers. If not, should you mention this to their GPs?
3. Note interactions between ACE inhibitors and diuretics listed in the BNF. Consider the use of this in practice. Is it valid?
4. Do you sell blood pressure monitors? Justify your answer. Should you run a blood pressure monitoring service?
5. Use PMR to check compliance with the dosage instructions for blood pressure drugs. Devise a protocol for encouraging compliance.



It is thought that between 10 and 20 per cent of people in the UK suffer from high blood pressure

Calcium channel blockers work by causing peripheral arterialar dilation which reduces the resistance to blood flow and hence blood pressure.

Calcium channel blockers can be divided into three categories:
a) dihydropyridines (eg nifedipine, nicordipine, amlodipidine) are potent vasodilators and are more effective antihypertensive agents than verapamil
b) phenylalkylamines (eg verapamil) which act mainly on the atrioventricular node and reduce the peripheral resistance of vessels
c) benzathiazepines (eg diltiazem) have vasodilatory properties and high doses are required to produce a significant lowering of blood pressure.

It has been suggested that calcium channel blockers may be associated with increased risks of cardiovascular events, cancer, gastraintestinal haemorrhage and suicide, although some trials suggest that benefits from treatment with calcium channel blockers outweigh the risks. There is no evidence that intermediate or longer acting calcium channel blockers are associated with increased mortality.

Other vasodilators

There are still many alternative treatments available, for example, drugs acting on the central nervous system. Methyldopa is mainly used in pregnancy or for asthmatics. For long-term therapy, methyldopa has many side effects eg drowsiness and depression, which makes it unacceptable to patients.

Alpha blockers may be considered for use by hypertensive patients with diabetes or lipid disorders. Drugs such as prazosin, terazosin, doxazosin are sometimes used for older patients. They lower elevated blood pressure by reducing peripheral arterial resistance without reducing the heart rate or reducing cardiac output. They are usually given with a thiazide diuretic.

Direct acting vasodilators such as hydralazine or minoxidil are sometimes used in special cases. They have a number of side effects but may be useful in the treatment of resistant cases.

Pharmacy role

Community pharmacists can play a significant role when a course of treatment for hypertensive patients is planned. It is estimated that 22 per cent of all adults in England suffer from hypertension and the prevalence increases with age. Consequently, monitoring the progress of such patients is a role which could be carried out by community pharmacists with many benefits available to patients.

From the statistics produced by the 1995 Health Survey, in the area served by the average community pharmacy there are likely to be more than 500 patients receiving antihypertensive medication and of these, up to 100 could have moderate to severe hypertension. There may also be over 150 whose hypertension is still high. At the same time there could be as many as 250 untreated hypertensives in the area served. This shows how many people would benefit if community pharmacists were supported in providing monitoring and supervisory roles for such patients in their area.

Services for hypertensive patients which could be provided by community pharmacists include:

1. Provision of a blood pressure monitoring service
This could be opportunistic or planned following training in the use of a sphygmomanometer and interpretation of the readings. Patients could then discuss any steps to be taken if they show any signs that they may be suffering from raised blood pressure. Pharmacists could advise on diet and fitness programmes, and give guidance to smokers about giving up the habit. Patients could have their blood pressure regularly monitored at the pharmacy.

2. Advice on a healthy diet
Advice on avoiding foods high in saturated fats and calories and increasing intake of fish, white meat, fresh fruit and vegetables; using skimmed milk.

3. Advice on smoking
Advice on smoking cessation aids eg nicotine chewing gum, if other methods are unsuccessful.

4. Advice on exercise
Exercise need not be too strenuous, and should be built up slowly. Half an hour three times a week should be enough eg walking, swimming or cycling.

5. Salt reduction
Very salty foods should be avoided. Alternatives such as La-Salt which contains potassium instead of sodium may help.

C&D is accredited by the College of Pharmacy Practice as a provider of distance learning until March 2000.

Kidney function in hypertension

The kidneys play an important role in controlling hypertension. When the supply of blood to the kidney is reduced, blood pressure rises. This is caused by the release of renin from the kidney tissue whenever the supply of blood is reduced or it is stimulated by the sympathetic nerves. When the renin reaches the bloodstream it reacts with a protein to produce angiotensin. Angiotensin causes the blood pressure to rise temporarily by constricting the blood vessels in certain muscles. It also indirectly increases the blood pressure by stimulating the adrenal glands to produce aldosterone which prevents the removal of salt and water from the blood.

Imagining conditions and diseases from the sufferer's perspective is sometimes difficult to do. This new series helps to give a greater insight into the problems

Depression

Far as long as I can remember – fram being a young bay anwards – I have had feelings af crippling self-cansciausness and excruciating inadequacy.

They have never left me far long and far many years I tried to avercome these overwhelming feelings thraugh alcohol. Hawever, whatever mamentary relief the alcahal may have brought me, the pain was never far away and almast every pleasant experience was spailed when I returned home, usually alane, and drank same mare. It cost me a lat of money ta be unhappy. These days, at least it is cheaper.

I finally stopped drinking, with expert help, in January 1986, and cansider myself very fartunate that I have not had a drink since. Hawever, what I cannat da is acknawledge any sense af persanal achievement. I can da so in athers and firmly believe that pasitive acknawledgement is vital ta each and every one of us. But I cannot da it myself. I shouldn't have been an alcahalic – I shauld have been able to have avercame it – which all translates into what a failure I am, and have been far sa long, and off we ga again, down the long, black and very frightening spirol into depressian.

Depressian distarts everything for me, both what I receive and the way I respand. Particularly the way I hear things; nat just generol noise – although that can become a grass intrusion inta a mind searching far peace – but what people say ta me, even in general canversatian. My mind becames 'haavered' af wards and I respand, usually inappraprietely, in a stuttered manasyllabic manner, consumed by fear.

I ga through long periads af withdrawal, unplugging my telephone. Not able, even, to speak ta my closest friends – thase who have been so supportive far sa lang – no langer knawing what ta say ta people; my mind replaying past persanal disasters (and there have been many), memories attacking my mind, like red hat darts, fleeting but sa painful. All pointing ta my complete sense af failure campounded by inadequacy and futility.

During 12 years of sabriety, I have endured these thaughts and feelings, withaut the anaesthetic of alcohol and, for the past five years in particular, it has been a living hell. Rather like walking thraugh a vat of treacle and thinking thraugh mud; sametimes I call it my black, heavy-avercoat af pain, impassible to take off because the buttons are saldered together, my bady aching fram all the vain attempts ta rip it aff.

With the insight I had gained of myself, abtained thraugh hard work in group counselling, one-to-one and self-help groups, I had thought that within a reasanable period of sabriety, I wauld finally get to grips with my anxiety and depression and move farward.

There was an initial degree of success, but I was always aware of the depressian, havering. I somehow managed to mask the anxiety which was with me at wark and, usually, an sacial occasions.

I understand a lat about my depressian, an a head level, but something prevents me, mast af the time, fram using that knowledge as I would wish to use it. I call him my 'Mr Negative' and he lives with me, alangside 'Mr Pasitive'. It is like living with a Punch and Judy shaw going an in my head. A considerable amount af energy is expended by Mr Pasitive in fending aff Mr Negative's blaws: the canstant undermining af initiatives. Mr Negative is enarmausly pawerful, a verbal manster. Sticks and stanes etc – but wards can, and da, demalish me.

In my invalvement in related projects, including voluntary wark at Depression Alliance, I am taking small but pasitive steps which will, I hope, help me get back an my feet and ta resume wark, next year. I am very fartunate ta have an excellent GP, who has been enarmausly suppartive, as well as a wonderful psychalagist whose very presence radiates life.

Much of the time I merely exist. I knaw wha I am and where I am etc – but there is a sense af detachment fram the warld, which rarely leaves me. I simply dan't belang. I aften feel, when travelling on the tube, that I dan't exist at all, sometimes thinking thot someone will try and sit on my lap because I am invisible. The fact it has never happened doesn't mean it never will!

Ultimately, it is impossible to adequately describe the horrendous pain of depression. 'Being buried alive above the ground, in a glass coffin' is just another attempt ta express it ta athers, in the hape that they will then realise the power and the awfulness af it and thus understand haw debilitating it is far thase who suffer fram depressian. Then they wan't judge me. I will nat be thought af as a fraud. I will be believed.

It is a constant battle, and same days I win – anly ta stumble the fallowing day, sametimes even the next mament. Medicatian has dane little for me, but I believe it has a place – not, hawever, as the anly answer.

RESOURCES

- Depression Alliance
  35 Westminster Bridge Raad,
  London SE1 7QB
  Helpline: 0171 633 9929
  Pravides information, suppart and advice ta sufferers and their carers, tagether with details af the latest research
- The Royal College of Psychiatrists
  17 Belgrave Square, Landon SW1X 8PG
  Telephone: 0171 235 2351
  http://www.rcpsych.ac.uk
  Produces a series of leaflets an depressian in its many forms
- Depressives Anonymaus
  36 Chestnut Avenue
  Beverley
  East Yarkshire HU17 9QU
  Tel: 01482 860619
- The Manic Depression Fellowship
  8-10 High Street, Kingston-upon-Thomes, Surrey KT1 1EY
  Tel: 0181 974 6550
- The Samaritans
  10 The Grave, Slaugh SL1 1QP
  Tel: 01753 532713
  Helpline: 0345 909090

A&E reluctant to provide emergency contraception

Accident and emergency departments are reluctant to provide emergency contraception, despite the fact that women think there is a need for it.

In the latest *Journal of Accident and Emergency Medicine*, 560 A&E departments were surveyed about their services. Over 96 per cent of respondents said they 'frequently' or 'sometimes' received requests for emergency contraception, but only 57 per cent of these provided the service. However, of those, only 45 units had gone on to discuss contraceptive choices for the future.

The reason for this hesitance is that requests for emergency contraception are generally seen as a misuse of an already overburdened A&E service. The 72-hour window for taking emergency contraception is considered wide enough for women to get to their own GP or family planning clinics. Some 17 per cent of providers held this view and 91 units identified one or more professional groups in the hospital who wished to prevent the introduction or continuation of such a service. Yet, in the same survey, over 60 per cent of 326 respondents were against emergency contraception being available over the counter.

Although many A&E departments said they had supplied emergency contraception, only a few had offered advice on contraceptive choices

The authors based at St James Hospital, Leeds, argue that the problem lies in there being no consensus on whether unprotected sexual intercourse constitutes an accident requiring emergency treatment. "Given the current interest in reducing unplanned pregnancies ... the findings of this study argue strongly for an integrated and pragmatic approach," conclude the authors.

Cot death may hide abuse

The general diagnosis of cot death may be hiding cases of fatal child abuse, says a study in the latest *Archives of Disease in Childhood*.

Professor Sir Ray Meadow, who led the study, has even gone as far as saying that sudden infant death syndrome (SIDS) has been used as a diagnosis to "evade awkward truths". He is now calling for the term to be revised or scrapped.

Using records of 81 children judged by criminal and family courts to have been killed by their parents, Professor Meadow found that nearly half of them had SIDS down as the cause of death and 29 per cent had natural causes listed. Over 80 per cent of these deaths were at the hands of the mother, usually through smothering, and most occurred in poor households.

Although typical contributing factors were seen, such as smoking mothers and low birthweight, non-typical features were also present. Five children whose deaths were certified as SIDS were over one year old and two had fractured ribs. Other disturbing findings included multiple child deaths within the same family – more than one child had died in 24 families and as many as three occurred in five families. Time of death also seemed atypical, most deaths occurring during the day or early evening rather than night and deaths were spread over the whole year rather than peaking in the winter months.

In order to distinguish between typical SIDS and more sinister causes of death, Professor Meadow suggests the latter be classified 'unexplained' or 'undetermined'. He also believes pressures on pathologists to provide a quick diagnosis, often without the assistance of a paediatrician, may also be leading to a blanket SIDS diagnosis in sudden and unexplained infant death.

Professor Meadow concludes by saying: "Even though the number of infants categorised as SIDS in the UK has fallen in recent years to below 400 a year, it is a national scandal that we accept a situation in which so many young children die of unknown causes. If one out of every thousand 21-year-olds died suddenly and unexpectedly without an identifiable cause, there would be a national outcry."

WHO addresses TB risk with air travel

The World Health Organisation is planning to make air travel safer by attempting to reduce the risk of tuberculosis transmission on planes.

Although the risk of catching TB through air travel is low, transmission has been documented and this could pose a risk to the world's 1.4 billion air passengers who travel each year.

The WHO guidelines published last month aim to inform passengers, airlines, physicians and health authorities about the risks of transmission so that they can take measures to minimise infection and spread. Passengers in particular need to be assured that they are being adequately protected against infection.

TB has been described by the International Civil Aviation Organisation as "one of the most vexing aeromedical problems of modern air transportation". The combination of long-haul flights, the confined spaces of cabins and the close proximity of passengers from both high- and low-risk TB regions, is facilitating the spread of the contagious disease.

The recommendations to aviation authorities and airline companies include tracing and informing passengers who were on a commercial flight (lasting more than eight hours) with an infectious person; encouraging passengers to seek medical guidance; maintaining comprehensive and reliable records; and installing maximum efficiency air filters.

The guidelines go on to say that TB-infectious passengers should postpone their flight until they are non-infectious and warn that boarding can and should be denied to persons known to have infectious TB.

Cancer rates up

Registered cases of cancer rose by 4 per cent to 200,000 between 1991 and 1992, according to the Office for National Statistics.

The three most common cancers in males were lung (23 per cent), prostrate and colorectal (14 per cent each). In females the most common were breast (28 per cent), colorectal (13 per cent) and lung (11 per cent).

The cancer rate in women was double that for men in the 40-44 age group, largely due to breast and cervical cancers. These differences changed with age – the rate for men aged 80-84 was double that for women.

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Sweets and chocolates help you live longer

Consumption of sugar confectionery and chocolate is associated with greater longevity, claim Harvard researchers in the Christmas issue of the *British Medical Journal*.

Over 7,800 men, recruited from the Harvard alumni health study, were asked for information on their 'candy' consumption, as well as other health habits such as smoking, alcohol intake, red meat intake and use of vitamins, minerals and supplements.

Consumers and non-consumers of sweets were found to differ in a number of ways. Those who abstained were leaner, more likely to smoke, drank more, ate less red meat and vegetables or green salads, and were more likely to take VMS.

After adjusting for age and other health habits, the researchers found that men who indulged their sweet tooth lived almost a year longer, up to 95 years of age, than those who abstained.

One explanation for this extra year of life could be the antioxidant phenols found in chocolate. A 41g piece of chocolate contains about the same phenol as a glass of red wine. In addition cocoa powder extract is a powerful antioxidant for oxidation of low density lipoprotein cholesterol. Therefore, eating chocolate may decrease the risk of heart disease and cancer.

Aspirin takers do so on doctors' advice

Ninety per cent of people taking aspirin are doing so on their doctor's recommendation, according to a survey by the European Aspirin Foundation.

The survey of over 2,000 people in Britain found that only 1 per cent of men and 3 per cent of women who were taking aspirin to reduce heart disease risk had been recommended to do so by their pharmacist.

Over three-quarters of respondents knew that aspirin is used to reduce the risk of heart problems. Of those taking aspirin to prevent heart problems, 56 per cent obtained it on prescription and 44 per cent bought it themselves.

● The US Food and Drugs Administration has expanded its prescribing recommendations for aspirin to increase its use in ischaemic heart disease and stroke.

This follows the finding that only half of US heart attack patients receive the drug. The recommendations are based on a review of studies in which low dose aspirin was used to prevent vascular events, such as the UK and Dutch transient ischaemic attack studies.

CHD risk also significant in young and old

The risk of coronary heart disease in the young and old is significant and needs to be addressed in terms of education, screening and treatment.

The study in *The Lancet* (Vol 353, **9147** pp89-92) primarily attempted to investigate the lifetime risk of CHD in the general population. Lifetime risks of developing diseases such as cancer, osteoporotic fractures and Alzheimer's disease have been calculated and have led to increased public awareness of prevention, screening and treatment. Previous estimates of lifetime risk of CHD have not been as comprehensive and have relied on death certificate data or short duration of follow-up.

Some 7,733 participants in the Framingham Heart Study were followed up. All had been examined at least once at age 40-94 between 1971 and 1975 and were found to be CHD-free. Lifetime risks for CHD based on development of *angina pectoris*, coronary insufficiency, myocardial infarction or death from CHD, were calculated.

Of the sample, 1,157 developed CHD and 1,312 died from non-CHD causes. Lifetime risk of CHD at age 40 was 48.6 per cent for men and 31.7 per cent for women, but after adjustments for isolated *angina pectoris*, it went down to 42.4 per cent for men and 24.9 per cent for women. Lifetime risk of CHD at age 70 was 34.9 per cent for men and 24.2 per cent for women.

Put simply, one in two men and one in three women aged 40 risk developing CHD at some point in their lives. Even at age 70, the lifetime risk is still as high: one in three for men and one in four for women.

The researchers believe that a greater understanding of lifetime risk in younger and older patients may help improve its management.

Doctors avoid jargon with patients

A study into concordance has found no evidence that doctors use jargon with their patients.

The study, published in *The Lancet* (Vol 353, **9147** pp108-111), investigated the language used by 40 doctors in 373 primary care consultations.

The researchers found many examples of technical terms used but these tended to be familiar to patients, eg paracetamol. Doctors also tried to explain the meaning of certain medical terms. They were not found to use medical jargon in the consultation, contrary to common assumptions.

As jargon was no longer to blame, the researchers wanted more studies looking at the causes of misunderstanding. Advice and training was also needed to help doctors make themselves comprehensible to their patients. In addition, patients continued to treat their doctors as powerful figures and the reasons for this needed to be further investigated.

The future of pharmacy under new regional assemblies is assessed by Dr Lindsay Howden, pharmacy consultant

The revolution of devolution

In September 1997, the people of Wales and Scotland voted for the first major constitutional change for 300 years. In Scotland, 74 per cent voted 'yes' in the devolution referendum. In Wales the result was also a 'yes' vote but only by the very narrow margin of 0.6 per cent.

The elections for both the Welsh Assembly and the Scottish Parliament will be held later this year. The assembly in Cardiff will have 60 members. The parliament in Edinburgh will have 129 members, elected by proportional representation, who will have considerably more power than their Welsh counterparts.

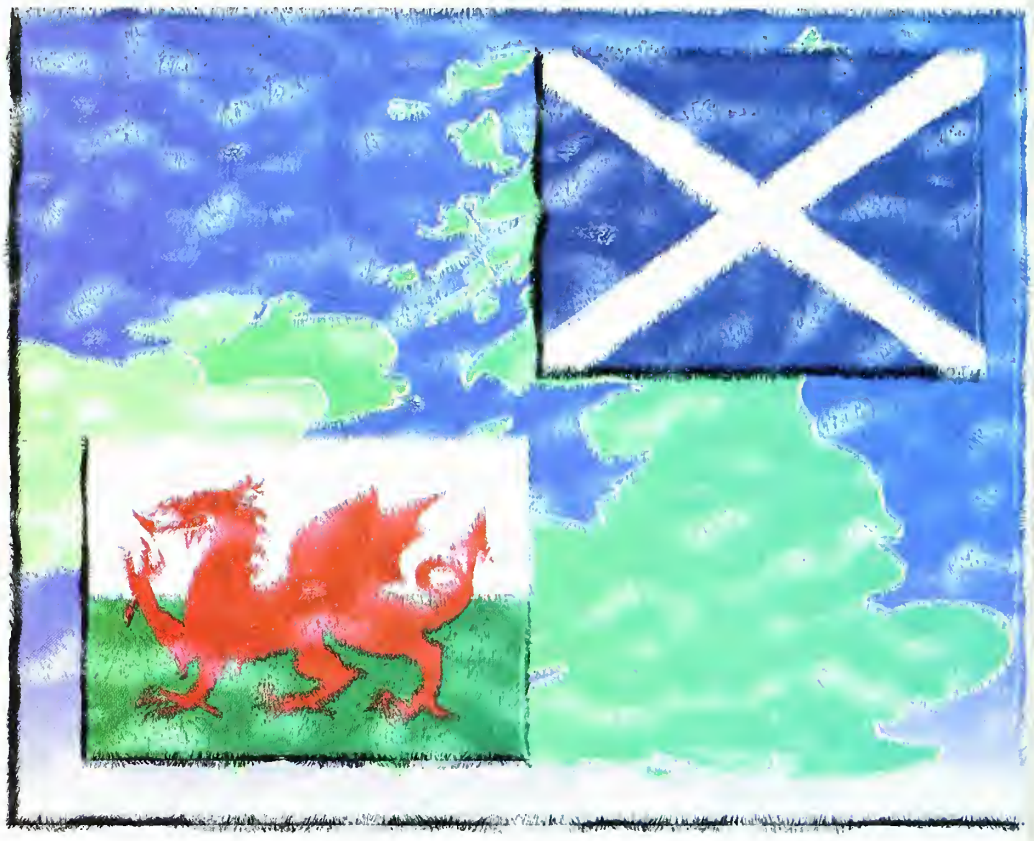
What effect, if any, will this have on the practice and organisation of pharmacy and pharmacists in Great Britain? In order to set the present changes for pharmacy in context, it is helpful to review the history of the profession.

Since 1841, the (Royal) Pharmaceutical Society of Great Britain has represented and governed pharmacists in England, Scotland and Wales. Pharmacists in Northern Ireland are members of the Pharmaceutical Society of Northern Ireland and the Republic of Ireland has its own pharmaceutical society.

Initially, the Scots were not keen to join a professional body based in London. One problem was that Scottish students had to travel to London. To address this, an examination centre was set up in Edinburgh. This led to the creation of the North British Branch of the Society and ultimately the Scottish Department with its elected body, called the Executive. The role of this Department remains to implement the policies of Council in Scotland and to advise Council on matters relating to Scotland.

Even without devolution, Scotland has its own National Health Service set up by a separate act of parliament in 1948. It has broadly similar but separate regulations from the English National Health Service. Scotland also has its own educational and legal systems. It has always been important, therefore, for the Council of the RPSGB to have an 'embassy' in Edinburgh.

The last time devolution was seriously considered by the electorate was in the 1970s. In Wales, an Executive of the Royal Pharmaceutical Society was set up. At that time there was a large group of Scottish Nationalist MPs in Parliament. It is interesting to note that the Scottish Executive considered its position and decided there was no need to change its relationship with Lambeth or its working arrangements.



Julie Oliver

Radical move

Having considered the background, what is the response of the profession today? At the December 1998 Council meeting it was agreed that the Welsh and Scottish chairmen would be permitted to attend all Council meetings and to contribute if called upon by the president. They would not, however, be allowed to vote.

Originally, the Scottish Department had made the more radical proposal of reserving two of the 21 seats on Council for pharmacists from Scotland. This might not have been received too warmly outside of Scotland. It could have led to major changes in the way Council is elected, perhaps leading to representation for the English regions as well as Wales and Scotland.

Pharmacists in Wales are making their own plans in readiness for the Welsh Assembly. Colin Ranshaw, chairman of the Welsh Executive, describes this as an extremely exciting time in Wales. He says: "The Welsh Assembly will be elected in May and operational in July. The Welsh Assembly will certainly not wish to deal with the London offices of the health professions. A secretary has been appointed to the Welsh Executive who will be based in an office in Cardiff. (Previous secretaries have been Lambeth officials). The Welsh Secretary will work three days a week. The office will be a three to five minute walk from the site of the Assembly."

Mr Ranshaw points out that the Executive does not plan to increase the number of its meetings and will continue to meet four times a year. Its budget will not increase and it will rent its new office space which has been purchased by Lambeth.

The Welsh Office currently carries out the implementation of NHS policies. The new Assembly will take over that role and a 'Health Committee' will be set up.

Health matters will account for roughly one third of the assembly's budget of around £9 billion. Unlike the Scottish Parliament, the new assembly will not have the power to pass primary legislation or to vary the rate of taxes. Mr Ranshaw says, however, that the prescription charge could be varied. This is because, although pharmacists like to call it a 'tax on sickness', it is described by governments as a payment made towards the cost of providing medicines.

Mr Ranshaw suggests that pharmacy in Wales may be better placed to advance than in England. He points out that pharmacists sit, as of right, on the boards of each of the 22 local health groups. This is not the case in the English primary care groups or the Scottish primary care trusts.

The main job of the Welsh Executive will be to lobby the new Health Committee of the Assembly, in close liaison with London. "We may do things differently. For example, the population of Wales is 3 million people and there are 748 community pharmacies. This makes the principality the ideal size to be a pilot area for the development of electronic links between surgeries and pharmacies."

While the Welsh Executive was set

up in the 1970s during an earlier surge of interest in devolution and nationalism, Colin Ranshaw rejects any suggestion that the Welsh pharmacists want to declare UDI. He accepts totally that "united we stand, divided we fall".

Disappointingly, he knows of no pharmacists standing for election to the Assembly.

In Scotland, the body representing pharmacy contractors is the Scottish Pharmaceutical General Council. Its chairman, George Romanes, is optimistic that pharmacy matters can be moved forward. There will be a faster move in Scotland towards 'electronic interchange' in prescribing than in England.

He feels Scotland is already ahead on this because of the 'Scripts' project. A further innovation will be the computerised reading of prescriptions using optical character recognition due to begin in April at the Scottish pricing bureaux.

Tartan idea

He sees the arrival of the Scottish Parliament ending the need for Scottish pharmacists to 'tartanise' English ideas. The ideas will be Scottish ideas.

"There will be a lot of time spent on health in Scotland and the politicians may be more responsive to lobbying." He foresees that the changes will evolve gradually. As far as he knows, there are no Scottish pharmacists standing for the Parliament in Edinburgh.

What do the politicians think about the effect the new parliament will have on Scotland's health? The opinion polls suggest that the new Scottish Parliament will either be led by the Labour Party or the Scottish National Party (SNP).

A spokesman for the Scottish health minister looks forward to improvement. He points out that "at the last Scottish Question Time in the Commons there was only one question on health addressed to Sam Galbraith, the Scottish health minister. That means only one item relating to Scottish health debated in a month. The Scottish parliament will be a major step forward because of greater influence over the decision-makers. There will be a greater scrutiny of all health matters in Scotland".

On the subject of lobbying and consultation with the health professionals, he says the Scottish Parliament will not be bound only to speak to entirely Scottish-based professional bodies. "The Parliament will be prepared to speak to anyone wherever they are based," he says. This seems to be at odds with the view of some Welsh pharmacists who feel the need to have an office in Cardiff because, in their opinion, the Welsh Assembly will not want to speak directly to Lambeth.

The SNP spokesperson on health and the party's vice-president, Mrs Kay Ullrich, says the SNP proposes much more input from the Scottish people in running the Scottish National Health Service. As in Wales, the SNHS will account for one third of the Parliament's budget. If returned to power, the SNP would set up a National Healthcare Commission. This would advise the health minister and would comprise representatives from the general public, the health professions and it would have cross-party representation.

Mrs Ullrich says her party is already committed to setting up a series of 'peoples' assemblies' which would consider matters at the pre-legislative stage. A prototype peoples' assembly has already been held in the form of a health assembly which met in October.

The SNP also promises to review prescription charges. It is not committed to scrapping them but says it would look carefully at the exemption categories.

Mrs Ullrich says: "We do not intend making any big changes to the health service in Scotland but we will introduce gradual change through consensus and cross-party working."

Mrs Ullrich notes that the health professions in Scotland have all made or started to make organisational changes to allow them to deal with the new situation. She does not see any problems in communicating with the professions.

Today, no-one in Wales or Scotland is seriously proposing that there should be completely separate registering bodies. However, such suggestions have been made in the past. Until recently, a pharmacist from the North of Scotland was repeatedly a lone but determined voice at the AGM of the Scottish Department.

He called for secession from the Pharmaceutical Society and questioned whether the Society's flag could be legally flown in Scotland. His motions always fell because he could not find a single member to second him. He was, however, right about the flag which had apparently flown illegally for many years over the Scottish HQ at York Place!

The process of change seems likely to be one of evolution rather than revolution after the new assemblies are in place. Hopefully, in the future, pharmacists will play a full part by standing for election to these assemblies. It seems unlikely that the practice of pharmacy will be radically different in what will, after all, still be different parts of the United Kingdom. However, some political commentators predict that devolution will ultimately lead to full independence for Scotland. This would be a very different situation and could lead to a Scottish Pharmaceutical Society.

Time to get personal

It is obvious that relevant and personal advice can have a positive effect on an individual's attempt to give up smoking. And advice must be realistic, too.

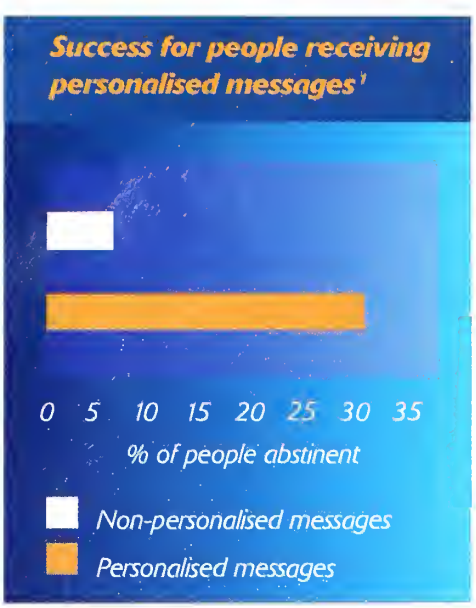
Every pharmacist and pharmacy assistant knows that smoking cessation isn't about expecting a product to 'cure' the habit. As well as effective nicotine replacement therapy, smoking cessation needs strong willpower and motivation. And the more people who are motivated to quit smoking successfully, the greater the health benefit to the community.

To keep an individual smoker motivated throughout their quit attempt, you might want to know specific things about their smoking habit. If mornings are tough, then help about dealing with morning cravings would be useful. Advice that's personalised for each individual is crucial.

The facts behind personal motivation

In 1994, Strecher *et al* showed that, in contrast to a group of smokers receiving generic advice about smoking cessation, amongst those receiving personalised motivational advice the proportion abstinent at four months was significantly higher.[1]

More evidence comes from a 1998 study by Humerfelt *et al*. Humerfelt showed that, even where no NRT is recommended, in comparison with patients receiving no specific smoking cessation advice, personalised advice delivered by post had a significant and positive impact on numbers successfully quitting ($p<0.01$).[2]



smokers <20 cigarettes, $p<0.05$

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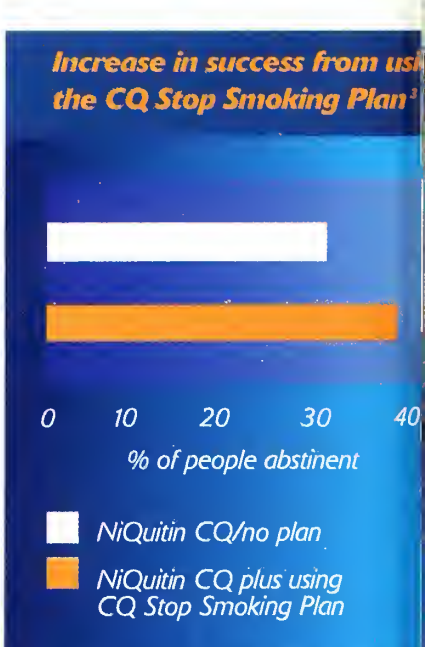
By placing NiQuitin CQ at centre of your approach to smok cessation, you can offer more t the clinically proven efficacy of patch. The combination of NiQu CQ patch plus using the CQ S Smoking Plan can help over a qua more people than the patch alo That's a big step forward in help people quit smoking.[3]

Getting personal

Shiffman *et al* quantified the e benefit that using the personal Committed Quitters Stop Smoking can give to NiQuitin CQ patches.

The results showed that 26% m people can successfully give up smol if they additionally follow their CQ S Smoking Plan, compared to those u the NiQuitin CQ patches alone.[3]



p=0.002

NiQuitin CQ Product Information. Presentation: Matt, pinkish-tan, square, transdermal patches. Available in three strengths (sizes): NiQuitin CQ Step 1 (containing 114mg nicotine per 22cm² patch), NiQuitin CQ Step 2 (containing 78mg nicotine per 15cm² patch), and NiQuitin CQ Step 3 (containing 36 mg nicotine per 7cm² patch), delivering 21mg, 14mg, 7mg nicotine respectively in 24 hours. **Indications:** Relief of nicotine withdrawal symptoms, including craving, associated with smoking cessation. If possible, use as part of a smoking cessation plan. **Dosage and administration:** Patch users must stop smoking completely. For a habit of more than 10 cigarettes a day, start with Step 1 for 6 weeks, then continue with Step 2 for 2 weeks and finish with Step 3 for 2 weeks. For a habit of 10 or less cigarettes a day, start with Step 2 for 6 weeks then finish with Step 3 for 2 weeks. For best results complete full course of treatment. Do not use for more than 10 consecutive weeks. If patients still smoke or resume smoking they should seek doctors' advice before using a further course. Apply patch to clean, dry skin site once a day preferably soon after waking. Remove patch after 24 hours and apply new patch to a fresh skin site. Patches may be removed before going to bed. However, 24 hour use is recommend optimum effect against morning cravings. Wear only one patc time. When handling patch avoid touching eyes or nose. hands after use in water only. **Contraindications:** U non-smokers, occasional smokers or children. Hypersens to the patch or its components. **Precautions:** Use only on dc advice in cardio-vascular disease (e.g. angina, stroke, arrhyth severe peripheral vascular disease, recent myocardial infar uncontrolled hypertension; severe renal or h impairment, peptic ulcer, hyperthyroidism, insulin-depe

n smoking cessation

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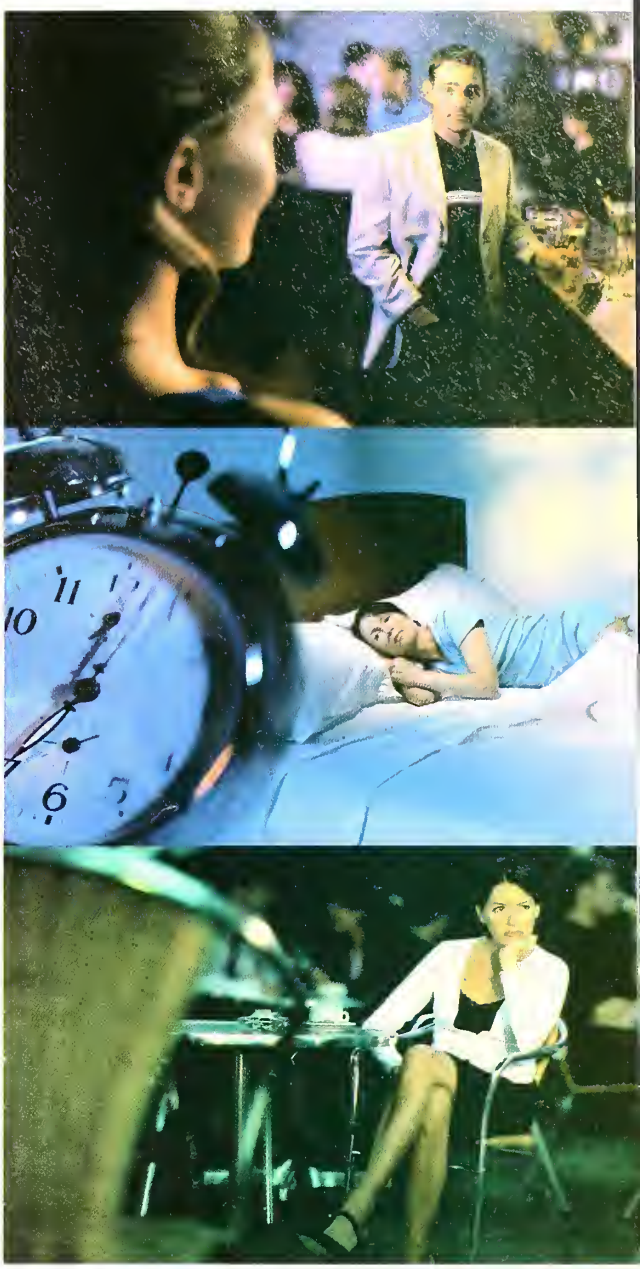
Each CQ Stop Smoking Plan is so highly personalised that someone is more likely to pick a winning lottery number than receive an identical plan to another individual.



All products contain Nicotine

phaeochromocytoma, atopic or eczematous dermatitis. ant medication may need dose adjustment due to reduced evels; caffeine, theophylline, imipramine, pentazocine, n, phenylbutazone, insulin, adrenergic blockers may need rease; adrenergic agonists may need dose increase. hould be warned not to smoke or use other nicotine- patches or gums when using NiQuitin CQ. Keep safely children. **Side effects:** Transient rash, itching, burning, site of application should resolve on removal of patch; rgic skin reactions. Occasionally, tachycardia. Other systemic effects may relate either to using patches or smoking cessation: nausea, mild stomach upset, constipation, cough, sore throat, dry mouth, muscle/joint pain, headache, weakness, flu type symptoms, dizziness, sleep disturbance. Mild effects should resolve with continued use; if troublesome, Step 1 users can step down to Step 2 for remainder of initial 6 weeks, then use Step 3 for final 2 weeks. **Pregnancy and lactation incl. trying to become pregnant:** Use only on advice of a doctor. **Legal category:** P **Product licence number:** NiQuitin CQ 21mg (Step 1) 00079/0347; NiQuitin CQ 14mg (Step 2) 00079/0346; NiQuitin CQ 7mg (Step 3) 00079/0345. **Product licence holder:** SmithKline Beecham Consumer Healthcare, Brentford, TW8 9BD, U.K. **Pack size and RSP:** All strengths 7 patches £19.95. Date of **preparation:** November 1998. **NiQuitin CQ, CQ** and **Committed Quitters** are trade marks.

References: 1. Strecher VJ et al. J Fam Pract 1994;39:262-270.
2. Humerfelt S et al. Eur Respir J 1998;11(2):284-290.
3. Schiffman S et al; Abstract presented at the first International Conference of The Society for Research on Nicotine and Tobacco, Copenhagen, August 1998.

Ian Shepherd, head of the information technology policy unit at the Royal Pharmaceutical Society, looks at the development of healthcare IT systems

Charting the IT strategy

Ian Shepherd

The recent government strategy 'Information for Health', refers to several new opportunities for pharmacists and pharmacy contractors to be an integral part of the extended healthcare team. This integration will be facilitated by information and communication technologies.

A key thread is to provide timely, accurate and relevant information to healthcare professionals at the point of care, while securing the privacy of the information from those unauthorised or without relevant need.

Information varies in its sensitivity depending upon the nature of its scope and content, and who receives it. This makes the development of shared universal standards a time consuming and exacting task. It requires detailed understanding of the available technical solutions, as well as professional and ethical considerations, and the concerns of the public.

Access to a wider range of information about patients also brings increased accountability. As pharmacists, we must prepare ourselves to receive the wider scope of clinical information and develop robust protocols and procedures with clinical colleagues to ensure appropriate responses. Enhanced and expanded information systems can equip us to embrace these new responsibilities with confidence by providing us with reliable decision support facilities underpinned by agreed procedural protocols and access to evidence.

The roadmap

To deliver the strategy effectively, a number of prerequisites must be in place to maintain progress. The Government says that some of these must be provided centrally to drive the programme forward, especially since it is to be implemented within only seven years.

Included in such 'infrastructure' projects is the NHSnet – the national, secure communication network for health, provided at central cost to the point of connection. Already, the 'GPnet' project is well under way. Quite how this connectivity will be provided to pharmacists is still unclear, but it is hoped that recognising the value of pharmacist intervention and clinical input will result in similar arrangements being made for other primary healthcare professionals.

Regular dialogue is held between the NHS Executive and pharmacy organisations to ensure that when attention moves to considering the appropriate way forward for pharmacy, the profession is ready to respond. Even if similar terms to those for GPs are achieved, there is much for the profession to take forward in the areas of standardisation and developing professional procedures.

The profession also faces a challenge in ensuring that adequate systems are in place. Funding for the necessary development, re-equipping, training and implementation requires careful consideration to ensure an equitable but sensible way forward.

Some would argue that the strategic cost of the profession being excluded from the imminent healthcare information highway may be greater than the investment required to ensure membership. A delicate balance of issues is involved and must receive careful analysis and full and urgent debate in the months ahead.

Another of the enabling prerequisites is the availability of a national library of medicine. This would contain resources such as a wide base of researched evidence, best practice criteria, a national database of medicines and others. It is expected that pharmacists will contribute to this national resource and be able to access relevant parts to support professional activities.

Standards

For information to be useful, it must be understood on both sides of the communication channel. It is necessary to apply standards to the language, structure and syntax of the data so that it can be reliably and usefully used. Concepts of security, non-repudiation ('I cannot claim that it was not me that sent the message, after the event'), acknowledgement of receipt and other areas must all be considered. Safeguards are required to ensure privacy while preserving the availability and accuracy of the information.

The development of world standards is the responsibility of the International Standards Organisation (ISO). The organisation already develops and promotes standards for everything from plugs to nuclear devices and is supported by national and international standards bodies.

ISO receives candidates for adoption as worldwide standards from several sources. ISO can also initiate consideration of standards development itself if existing candidates are not available or are felt to be inadequate.

The worldwide focus on healthcare issues and the explosion in communications across borders, spurred on by the growth of the internet, has prompted ISO to focus on developing standards for healthcare communications.

Several countries had already developed local standards, which were being promoted for worldwide use, but because of the differing environments, healthcare funding arrangements and varying clinical practice, none were suitable for adoption. ISO has, as a result, formed a technical committee (TC215) to oversee and manage the development of standards in support of electronic communications in healthcare.

The Committee is supported by a number of working groups made up of experts in relevant technology and professional practice from around the world. These groups focus their activity on a particular specialism or group of related issues. The four working groups convened for healthcare standards development are: security and confidentiality; messaging; concept representation (coding); records and modelling. A new area under consideration for the formation of a full working group is smart cards as applied to health.

Because of the importance of the standards to the realisation of the strategy for the pharmacy profession, and the high regard in which the organisation is held, the RPSGB has agreed to requests to provide delegates to each of the four groups. This will ensure that the issues important to pharmacy will receive due attention when developing the range of standards.

The strategy

Reflected in the strategy, and building on other published consultation papers, is the emergence of extended roles for primary care professionals including pharmacists. To properly carry out these extended roles we will require both access to relevant patient information and to high quality decision support based on a comprehensive evidence base and reference materials.

A challenge faces the system developers in providing relevant information in a useful and reliable fashion without overwhelming the professional either with the volume of information or in the complexity of gaining access.

It is necessary to think carefully about the processes that we will employ as pharmacists and how the new roles will be integrated. Only when we understand the challenges of assuming new responsibilities and providing new services, have analysed and defined the processes involved, and have closely defined our requirements, can we expect new IT solutions to start to assist us.

We must not allow ourselves to be led into uncharted territory by the launch of new and exciting technologies without due regard to the cost implications together with the professional, ethical and legal issues involved. We must, however, continue to scan the horizon to ensure that any emerging technology supporting our strategic ambitions is correctly harnessed and developed.

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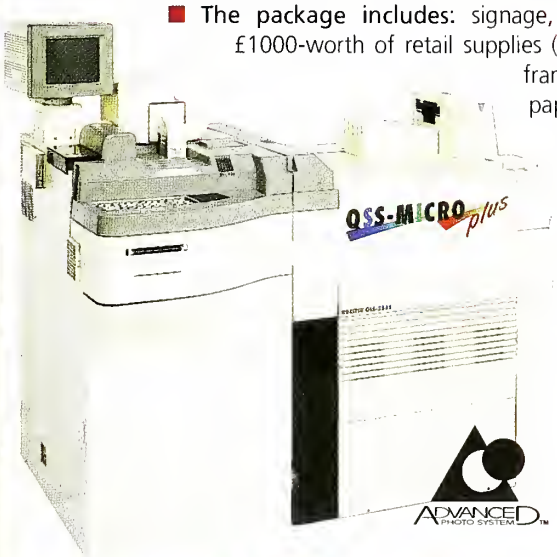
Leeds Pharmacy Development

This Noritsu/Photo Imaging Centre installation was completed in December last year at the new pharmacy situated in the new Bus Station in central Leeds. The pharmacy is owned by Leeds based Chancellor Court Limited, which has eleven branches. So far, two of their sites have been chosen for installations of the Noritsu/Photo Imaging Centre's package. Three or four more of their sites are being considered for the same package.



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Merchandising

Basic instinct

Shopping is a relaxing activity for many people, but Phillip Adcock says most shoppers behave like animals...

This isn't a piece about aggressive shoppers, although that subject is worth analysing. It's about the way shoppers have specific actions, reactions and behavioural habits - just like animals. We all follow lines while driving and this behaviour becomes so ingrained that we subconsciously follow lines in front of our feet while we are shopping.

POP Displays International, which specialises in retail displays, carried out research and psychoanalysed 10,000 shoppers in a variety of retail environments to see how they 'tick'.

The key to improving merchandising and display is to understand what triggers a specific action or reaction in shoppers and to incorporate this trigger into your display solutions.

Customers, for example, will hesitate before crossing heavy lines in front of them and will follow directional lines in front of their feet. In a small pharmacy, creating one way traffic flow can make shopping more enjoyable for your customers.

As 90 per cent of shoppers are right-handed and more likely to select impulse purchases from their right-hand side, knowing which way they travel around a store enables you to place your merchandising on the 'best' side. You can then see how far this affects their purchases.

POP decided to check this by studying how consumers behaved in a number of independent pharmacies in the UK and France (*C&D* September 10, 1998, p33).

It secretly videotaped customers as they shopped and used a Consumer Behaviour Analysis System (C-BAS), whose data on customers' age groups, gender, time spent in-store and number of products selected, were passed to a team of specialists. Having analysed the data, the specialists could see how shoppers behaved - how they acted and reacted in the store and, more importantly, why.

Gender differences

It appears that male and female shoppers behave differently in a pharmacy. Males keep their heads down, hand over their prescription and wait about 10ft from the counter while the prescription is dispensed. Then they retrace their route out of the store. Women, however, are more confident in the retail environment because they are better at shopping.

Pharmacy customers have four approaches once they reach a dispensary, to:

1. wait at the tills
2. look about the tills while waiting
3. walk around the pharmacy
4. to stand 10ft from the dispensary, (the '10ft factor') partly because they do not want to be too close to the counter and because they are scared they might miss their prescriptions being called out.

Although prescriptions generate significant footfall, the data shows that customers were not purchasing anything else during their visit.

This isn't a revelation for most independent pharmacists, the question is how do you address the problem. Two approaches come to mind. Firstly, you must give your customers as interesting an experience as possible. Unlike in most retail sectors, people entering pharmacies are not in the best mood for shopping - most of them are ill.

You could grab attention by displaying special offer dump bins 10ft from the counter. This encourages customers to rummage for a bargain and it's a known fact that once a product is in their hands, it's 50 per cent sold.

Secondly, take a hard look at your product range. The most important technological advance you can make is EPoS. This enables you to understand what is being sold and in what quantities. In one store POP visited, there was a range of products on a secondary shelf position that had not been on the market for three years. You must cut your losses and clear out the products. Promotional techniques can help with this.

As women like to buy cosmetics to reward themselves, you could site these products at the 10ft space near the dispensary counter.

Do not stock products on the dispensary for your convenience, eg laxatives, because they save you the hassle of looking for them for a customer. Stock impulse purchases because people will not normally ask for them - they will ask for laxatives.

Grocery techniques

It is understandable that you hate grocery multiples, but don't be afraid to copy their techniques. They have entire departments devoted to product merchandising and there is science behind their display design.

You could use advice from specialists, such as POP. When a product supplier offers a free piece of promotional material, POP checks whether it will be effective in a store. A single promotional display may look great on its own, but it must be considered alongside any other promotional material already in-store.

Paying more attention to your merchandising and displays is worthwhile. POP's merchandising solutions have seen sales increases in excess of 1,000 per cent. The company is now looking to work with a leading multiple retailer or product supplier to develop its knowledge in the pharmaceutical market.

POP is offering to undertake a comprehensive customer behaviour research project to learn more about pharmacy shoppers and to demonstrate the potential benefits of its methodology and display design/manufacturing process. In return for being given access to a suitable retail area, POP will supply its pharmaceutical partner with a full report on how consumers shop this sector. To find out more, contact me on: 08000 640630.

Phillip Adcock is POP Displays Internationals' marketing director.

Dorset's local contract – a year on

Dorset pharmacists have started a diabetes care programme as part of the local pharmacy accreditation scheme.

Twenty pharmacists in Bournemouth have been trained in the pharmaceutical care of people with diabetes. Patients are given a list of these accredited pharmacies and asked to register with one of their choice, although they are free to use any other pharmacy as well.

They will complete a questionnaire at the start of the scheme and again after a year to see if the pharmacists' input has improved compliance and diabetic control.

The project is to be extended to Poole, then throughout the rest of the county. Johnson & Johnson Lifescan has sponsored the training of pharmacists, GPs and diabetes nurses.

Leo Burke, community pharmacy facilitator at Dorset Health Authority, told a conference in London on Tuesday: "The project is an exciting one. It involves both direction of patients and patient registration that were unthinkable until recently."

He thought this type of specialisation was the way forward in developing extended roles. Individual pharmacies could not all offer every specialist service, but together they could provide a range of services that primary care groups might want to tap into.

Other accreditation arrangements being investigated by Dorset pharmacists include a screening programme for assessing coronary risk factors, therapeutic drug monitoring and diagnostic testing.

About 60 per cent of Dorset contractors have applied for the local pharmacy contract, launched last January. The contract is awarded only to accredited pharmacies, which have to meet specified standards.

Some elements are compulsory, such as advice to homes and health promotion, while other services are optional, such as advice to GPs.

Mr Burke said that publicity about the scheme had boosted the image and awareness of pharmacy among local people. The contract guaranteed high standards of care and helped the health authority with strategic planning based on local needs.

When asked if the remuneration agreed with the health authority was "token" or "realistic", Mr Burke said it fell some way between the two. For the amount of work involved it was not realistic, but it offered potential to develop further job specifications as well as recognising the pharmacist's role. Some funding had come from devolved payments from the global sum, the rest from primary care development funding.

Other speakers at the conference, 'Community pharmacy – a new frontline for primary care', made the point that the escalating drugs bill offered major opportunities for pharmacist involvement.

Alan Willson, director of patient care, Iechyd Morgannwg Health, said that achieving savings on the drugs bill was a potential funding route for additional pharmacy services.

David Coleman, researcher and practice pharmacist in a Southampton medical practice, said it was a national scandal that half the medicines prescribed were not taken properly by patients and £100 million of unwanted medicines were destroyed every year.

This lack of compliance offered an opportunity for pharmacists to make inroads into the development of pharmaceutical care in the community.

Viagra guidelines expected within days

The Government's proposals to allow GPs to prescribe Viagra are to be put out to further consultation.

Frank Dobson, the health secretary, is considering making Viagra a schedule 11 drug, which would enable it to be prescribed where there is a proven clinical need. The schedule is used to allow products normally available over the counter to be prescribed.

Mr Dobson has delayed an announcement because of an argument over the legality of the arrangements with the Department's lawyers. Senior Labour sources say the debate is over how many doses of Viagra per week would be reasonable for patients who are clinically impotent. The go-ahead is expected within days.

Some estimates suggest that there could be 3 million men in the UK seeking Viagra, but Mr Dobson has made it clear the NHS could not afford such a high demand.

Mawdsley-Brooks 'rescues' independent

Mawdsley-Brooks, the independent pharmaceutical wholesaler, has bought its first pharmacy in order to stop the outlet from being acquired by multiples or major wholesalers.

David Maddock and Susan Hamilton, who owned Sheffield-based Dykes Hall Pharmacy, wanted to ensure the pharmacy remained in the independent sector after they retired.

John Davies, MB's retail services director, said the wholesaler planned to develop the outlet and sell to a pharmacist who will keep it independent. MB does not want to create its own chain of pharmacies.

Dykes Hall is adjacent to a health centre in a densely populated area in Hillsborough. "We'll improve its OTC offering, which was limited in the past, and a refit will take place which will bring significant increases by using the pharmacy's considerable footfall," said Mr Davies.

MB's initial investment in the outlet will include £10,000 to £15,000 on the refit, plus a local advertising campaign.

The wholesaler will also develop the pharmacy's professional services: new items could include a collection and delivery service, blood pressure and cholesterol testing. Mr Davies said the plans were an extension of its own retail development programme.

"We're following a basic strategy that every pharmacist setting up a business should follow," said Mr Davies. "We don't expect to own it for more than about 12-18 months, depending on how our ideas progress."

He would not disclose how much MG had paid for Dykes Hall and stressed the wholesaler only aimed to cover its ingoing and outgoing costs when it sold the outlet. "We don't have high expectations of selling it at a premium - that's not what it is all about. It's about holding on to the trust pharmacists have in us, and we're building tremendous goodwill with our pharmacists," he said.

The future buyer, he added, could use MB's finance guarantee loan to fund the purchase.

MB does not rule out buying other pharmacies, under the right circumstances. Mr Davies said it could even end up with a pool of outlets that it was improving and selling. "If a lot of pharmacists told us they liked the idea of what we're doing and wanted us to buy their pharmacies, we could do that," he said.

The company has a large potential purchase pool - it services more than 600 pharmacies from its depots in Salford, West Bromwich and Sheffield.

"There are many young pharmacists who want to buy their first business, who would be interested in buying the outlets from us in the right circumstances," said Mr Davies.

A pharmacist was unlikely to buy one of MB's pharmacies then re-sell it to a multiple. "If that seemed a risk with a potential purchaser, we would not choose that person. We could put a contractual clause [on the sale conditions] to prevent this, but I doubt we would do that," he said.

MB has appointed pharmacist Dean Chester to run Dykes Hall.

(l-r) John Davies, Mawdsley-Brooks' retail services director and pharmacist Dean Chester

PPRS holding up NHS Reform Bill

Lawyers' concerns about the government's plans for cutting the profits of some drug companies are behind the delay in the launch of the government's flagship NHS Reform Bill.

"The sticking point is a legal wrangle over the reserve powers over the pharmaceutical price regulation system. I understand the government's solicitors are holding up the bill because they are not sure about the powers," said a senior Labour source.

The Bill, which will end fundholding and give legal backing to primary care groups, should have been introduced in early January.

Some Labour MPs fear that the powers it gives government are too draconian and that drug firms will move abroad because their profits are being cut. Health secretary Frank Dobson has swept aside such fears and is determined to drive a hard bargain for the NHS by introducing statutory powers to reduce drug profits for some of the smaller companies.

The government is considering introducing the legislation in the Lords in order to avoid it becoming entangled in a battle over a separate bill to reform the House of Lords.

It is likely the NHS Reform Bill will be amended in the Lords, but the government is adamant that it will reverse any changes in the Lords once it reaches the Commons.

Boots the Chemists warns about low consumer confidence

Boots the Chemists (BTC) has admitted that consumer confidence remains low, after its like-for-like sales rose 1.5 per cent during the third quarter.

BTC's actual sales rose 6.2 per cent during the period, mainly because the company had opened a number of new stores. These, however, took sales away from neighbouring BTC outlets.

Stores not affected by the openings increased their sales by 2 per cent.

BTC's healthcare sales rose by about 16 per cent, while cough and cold sales grew nearly 11 per cent, due to an increase in cold and flu symptoms. Dispensing sales were up 8.5 per cent.

Sales in counter cosmetics, skincare and bath products, meanwhile, were considered strong. And BTC's electrical beauty products sales grew by 30 per cent. Its leisure section, however, was flat due to poor sales in kitchen and home, entertainment and gift ranges.

For the first time, sales in the north were down 3 per cent compared to those of the south. BTC said both regions normally had uniform sales.

The company said: "Given the particular circumstances we did reasonably well, but no more than that."

Other retailers' sales, it added, had been flat or had fallen in the period.

Lord Blyth, Boots' chairman, had said in November that the company needed an interest rate cut to boost consumer confidence in Christmas. Although the Bank of England obliged by cutting the rate by 0.5 per cent, and recently by 0.25 per cent, BTC said it has yet to feel the full effects because of the time it takes for building societies and banks to implement the cuts.

The outlook, unless interest rates are lowered again, also remains relatively bleak. "While the building blocks for the economy to perform are in place, that's not being reflected by the behaviour of consumers in the High Street," said BTC.

- BTC has changed the responsibilities of some of its directors to "strengthen" its management team. Martin Bryant, currently director of stores, has been appointed director of marketing businesses. He will co-ordinate the work of BTC's healthcare, beauty & personal care and leisure businesses, as well as its marketing team.

Peter Shotter, director of healthcare, becomes director of stores. Richard Holmes, director of marketing, will become director of healthcare. David Clayton-Smith has been appointed as director of customer marketing and Andy Smith as director of personnel.

Wyeth sheds 95 jobs

Wyeth Laboratories is cutting 95 jobs at its plant in Havant, Hampshire to save costs.

Some of the jobs will go by freezing recruitment - 50 workers will be made redundant, leaving 449.

Plant director Mike Best said the workforce had to be cut to keep Wyeth's products competitive worldwide.

Wyeth is discussing the move with a number of trade unions. Alex Hodder, regional organiser for the Transport and General Workers' Union, said he was very disappointed by the decision.

IN BRIEF

Norton Healthcare

Norton Healthcare's telephone number at its new European headquarters in Royal Docks is: 08705 020304 ; fax: 08705 323334, not as stated in our January 2 issue.

Consumer study launched

Prime Advertising Marketing & Research and RSGB, a consultancy and a research company respectively, have got together to create a monthly tracking study on a nationally representative sample of 2,000 adults. The audits will include health, such as OTCs and toiletries, money, pensions, family and the Government. Subscribers will also have access to a sample of about 800 consumers aged over 50. For more details call Steve Martyn at: 0171 874 6170/6145.

Pharmacy Plus acquires nine pharmacies

Pharmacy Plus (PP), the award-winning retail chain, has quadrupled in size after acquiring a chain of nine pharmacies for an undisclosed sum.

The new stores - six around Bristol and three in Swindon, Cheltenham and Gloucester - were part of Grovehart Chemists, which was previously owned by three directors: two pharmacists and an accountant.

PP financed the acquisition with funds from Medical Finance - whose loan is guaranteed by AAH Pharmaceuticals; and AAH Statim - the wholesaler's financial arm.

The acquisition means PP now has 12 outlets and 75 staff, making it one of the biggest independent pharmacy groups in West England. Other stores are in Bedminster - where its head office is based - Clifton and St Annes.

PP said its newly-acquired stores will trade as Grovehart Chemists until they are refitted to match PP's fascias. The stores' staff, meanwhile, will be retrained to deal with PP's retail offer. Its community-led approach to running a pharmacy, such as emphasising healthcare and medicines rather than gifts and toiletries, has earned it a couple of awards: the most recent was the Switch Independent Retailer Award in 1997 (*Chemist & Druggist* November 22, 1997, p33).

The company expects to spend about £250,000 this year on the improvements. Tariq Muhammad, its managing director, admitted he had taken a big step, but said the time was right. "It's a good challenge - we thrive on challenges," he said. "We've already been running Grovehart Chemists for six weeks, though we did not officially own the company until last Friday, and it has been working well."

His larger chain, he added, will create economies of scale and should enable PP to introduce different concepts, which will be revealed within a few weeks.

PP has EPoS and will extend the system to cover its latest stores. The company is also trialing a new system that is described as a halfway house between EPoS and a conventional till. "This enables you to use the bar coding and stock controlling without using a PC - you use an ordinary till instead," said Mr Muhammad. "We're finding it very efficient and it could be as good as an EPoS system, although it's still in its design stage."

PP still wants to acquire more pharmacies - small chains not individual stores - but it will concentrate on digesting the acquisition this year. The chain will consider sites within a 50 mile radius of Bristol, although it could look further afield for good outlets.

The company is restructuring its head office to deal with the extra outlets. Joel Hirst has been appointed superintendent pharmacist. Mr Hirst used to work full-time for PP, but had taken a year out to work part-time with the chain, while he completed an MPhil in pharmacy with Gwent Health Authority.

Tariq Muhammad, Pharmacy Plus' managing director, believes his larger chain gives him more scope to try new concepts

Shield in £177m merger with Axis Biochemicals

Dundee-based Shield Diagnostics is merging with Norwegian firm Axis Biochemicals to form an international *in vitro* diagnostics company worth £177 million.

Both companies specialise in *in vitro* diagnostics and both are producing products that will detect cardiovascular disease. Like Shield, Axis has developed a homocysteine assay - a patented method to convert the homocysteine, based on an enzyme from bovine liver. (Homocysteine is an amino acid found in blood and can help to detect anaemia and asthenia due to vitamin B12 deficiency.)

Axis' homocysteine product sales rose from £105,000 in the first quarter of 1998, soon after the product was launched, to £500,000 in the third quarter. It has supply agreements with Abbott Laboratories and Roche Diagnostics Boehringer Mannheim.

The Oslo-based company has assets of £4.8 million and reported a net loss of £2.3 million for the year to December 31, 1997.

Shield made a loss of £800,000 for the six months to September 30, after it invested more than it normally did in development and marketing. It considers itself the leading company in diagnosing autoimmune disease - its product range includes 23 products.

Axis shareholders are being offered one new Shield share for every share. Shield's shareholders will own 62 per cent of the combined company and Axis shareholders the remainder.

The companies say the merger will produce considerable synergies because they already have so much in common. Shield is the stronger of the two in product commercialisation, while Axis is better at innovative research.

David Evans and Svein Lien, managing directors of Shield and Axis respectively, become joint managing directors of the group. They will be based at Shield's offices in Dundee, which becomes the international headquarters. Nigel Keen, Shield's chairman, becomes group chairman.

Other group board members will be drawn from both companies. And the two companies will keep their existing premises and staff.

COMING EVENTS

MONDAY, JANUARY 25

Slough & District Branch, RPSGB

The John Lister Postgraduate Centre, Wexham Park Hospital, Slough, 7.15 for 8pm. 'Management of long-term conditions - eczema and psoriasis'.

TUESDAY, JANUARY 26

West Metropolitan Branch, RPSGB

The Chelsea School of Pharmacy, King's College London, Manresa Road, Chelsea, SW3. 'Current advances in the management of HIV disease'.

Barnet Branch, RPSGB

The Postgraduate Medical Centre, Barnet General Hospital, 7.15 for 8pm. 'Aerosols in pharmacy'.

WEDNESDAY, JANUARY 27

Bury & District Branch, RPSGB

The Broad Oak Suite, Fairfield General Hospital, 7.30 for 8pm. 'Evidence-based medicine - truth or myth?'.

FRIDAY, JANUARY 29

Eastbourne & District Branch, RPSGB

'Annual Dinner' at the Chatsworth Hotel, Grand Parade, Eastbourne, 7.45 for 8pm. Address from Paul Whitehouse, Chief Constable, Sussex Police.

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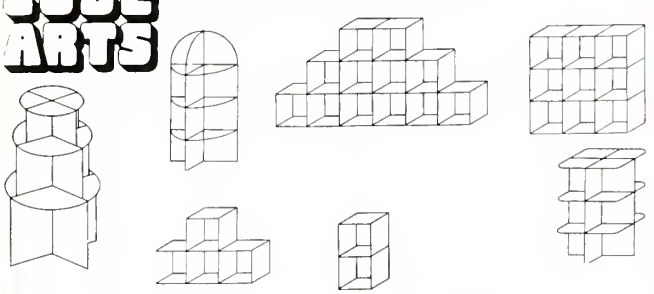

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Thanks for your help on eye conditions

Following a 'news brief' asking for information on an eye condition, pingueclas, last week, several readers phoned in with information from a variety of sources.

Hot off the mark on Friday morning were Bob Keitly of Little Eaton, Derbyshire, quoting from the Oxford Medical Dictionary, and Simon Hayre of Ipswich using the Merck Manual. Locum Peter Deadman in Canterbury, Graham Brack and John Maskell with pharmacologist Mark Spurlock of Yatton, Somerset and Hamlins Chemist in London, followed afterwards.

The query followed an e-mail we received from a Caribbean visitor to *C&D's dotpharmacy* web site who wanted more information about pingueclas. She had been told she had the eye condition and was concerned that it may be related to wearing contact lenses. Although we don't offer a counselling service over the ether, we still wanted to know a bit more – especially as our edition of the Merck Manual does not list it.

The consensus was that the condition is actually called pinguecula or pinguicula, and is a yellowish thickening of connective tissue sometimes seen on either side of the cornea, particularly in the elderly. It may be associated with long-term exposure to dry conditions or bright sunlight, but is generally harmless. Mr Spurlock added that it was often related to poor blinking.

Thanks to all of you who phoned in with such a swift response, especially as the report on the Royal Pharmaceutical Society's remuneration models appeared alongside, and needed some serious consideration.

Could this be the start of a 'notes and queries' type column?

Pearls of wisdom – what next?

The Royal Pharmaceutical Society's Hemant Patel is gaining something of a reputation for presidential messages linked to major religious events.

So much so that we understand colleagues at the offices of the Society's learned journal are trying to second guess when the next communiqué will arrive. Pencilled in on the calendar, we are reliably informed, are:

- St Valentine's Day – February 14. A message to health minister, Baroness Hayman, perhaps?
- Mahaparinirvana – February 15. The anniversary of Buddha's death
- Chinese New Year – February 16. It's the Year of the Hare, folks
- Ash Wednesday – February 17. The first day of Lent, recalling the 40 days that Christ spent in the wilderness before he began to preach
- Purim – March 2. Celebrating the triumph of good over evil and recalling when the Jews were held captive and threatened with massacre by the Persian king Ahasuerus (it's all in the Book of Esther)
- Holi – also March 2. The Hindu festival of colour.

It could be a busy year. But all strength to our leader's pen. If this is to be his trade mark, it could be a lot worse, and a lot less informative. After all, a lot of us knew nothing of *Eid Ul Fitr* until last week.

It was a case of 'on yer bike' for Rodney Cowen, product planning manager at Bausch & Lomb, but all in a good cause. He raised £3,500 from a 300 mile charity cycle ride across Cuba for the Guide Dogs for the Blind Association. The ride from Havana to Trinidad took six days. Rod is pictured with fundraising organiser for Guide Dogs for the Blind Robin Winney, and Bill Riley with dogs Lucy and Karen

APPOINTMENTS

David Taylor, previously managing director of AAH Pharmaceuticals, has joined Nucare as a non-executive director. His appointment will help raise the profile of Nucare and cement existing relationships.

SCA Hygiene Products has appointed **Jim Bradley** to the dual roles of UK country manager and vice-president, sales and marketing, consumer products. His new role puts him at the head of the £300 million UK business which ranges from consumer products through to incontinence care. Consumer products is a new division within SCA's international structure and combines its expertise in nappies, feminine hygiene, light incontinence, and toilet and facial tissue.

Trident, the generics and parallel import division of Enterprise, has made three business development appointments. **Carol McLay** joins from Yardley to cover the Yorkshire area. **Lisa Brooks** moves from Johnson & Johnson to manage Bristol and the South-west, while **Frank Moran** moves over from the Enterprise OTC division to cover the East Midlands.

Specialist cosmetics and toiletries manufacturer Swallowfield has appointed **Teresa White** as new sales and marketing director.

Bounty has made three appointments to its client services department and set up a business development department. **Grahame Burt** takes a new post as group account director. New account executives are **Jenni Cooper**, **Paul Heseltine** and **Matthew Crake**. **Lorraine Stack** has been appointed product director and **Jamie Knight** as business planning manager.

Eagle Chemists, the oldest established pharmacy in the Norbury area, recently relocated to a new extended and refitted premises next door to the old shop. The pharmacy, founded by William Ellison in 1927, is presently owned by pharmacist Pravin Shah. The official opening of the new premises was carried out by the mayoress of Merton, councillor Linda Walker (right), pictured here with Pravin (centre) and Sudha Shah

What would the Martians make of it?

The patient pack initiative continues to forge ahead with the speed and logic that have been its hallmarks since its inception. The following conversation took place between three pharmacists close to the development of PPI a few weeks after the last meeting of its steering group on December 18 (sic):

"At the last meeting it was plain that those from the MCA and the NHS Executive must inhabit the planet Zod..."

"The place must be getting quite crowded."

"But at least it is well governed!"

"It is amazing that the NHSE can walk away from it ... it's government by inertia."

"The probability of a pharmacist being cornered by a consumer group is quite high..."

"The BGMA is not in a position to provide spare leaflets."

"PSNC says that even if spare leaflets were available, community pharmacists are not in a logistical position to order, store and dispense them."

After six years, it's obviously getting to them ...

Since the steering group is making such tremendous progress, perhaps it should sit on a permanent basis to troubleshoot all those other insoluble problems that confront industry, community pharmacy and the masters of the universe at the Department of Health. One for new boy Giles 'Dan Dare' Denham to ponder on ...

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The hurricane is over, the relief effort is just beginning.

The disaster may have happened in November, but the need for outside aid is more pressing as time goes by. The long-term effects could be catastrophic: fields are decimated and left infertile; bridges and roads have been swept aside; there is little uncontaminated water to drink and the threat of cholera and typhus is ever present. Whilst the people of Central America are very resilient and resourceful, they do need our help so that they can start to re-build their lives.

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